September 14, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
Submitted electronically to: https://www.regulations.gov

RE: CY2027 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Oz:

The National Association of Accountable Care Organizations (NAACOS) appreciates the opportunity to submit comments in response to the calendar year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule. NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) and value-based care entities in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve the quality of care for patients and reduce health care cost. Collectively, our members are accountable for the care of more than 10 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model.

NAACOS applauds the Centers for Medicare and Medicaid Services (CMS) for its continued commitment to modernizing and growing ACOs. We sincerely appreciate that CMS incorporated stakeholder recommendations to improve long-term sustainability, expand participation, reduce administrative burden, and strengthen primary care. Specifically, the guardrails on the Accountable Care Prospective Trend will help ensure that ACOs are not unfairly disadvantaged by forecasting errors. The changes to quality reporting, Certified Electronic Health Record Technology (CEHRT) attestation, and beneficiary notifications will meaningfully reduce administrative burden, allowing ACOs to redirect time and resources toward patient care and care delivery transformation. Finally, bringing tested Innovation Center model approaches into MSSP, such as beneficiary cost-sharing support, gives ACOs additional tools to develop care approaches tailored to the needs of their populations.

Accountable care has consistently demonstrated its ability to improve quality and reduce costs, with $37.4 billion in savings since 2012, and outperforming traditional Medicare fee-for-service in key metrics including stronger disease prevention and lower hospitalizations, preventable admissions, and readmissions[1]. When provided with timely data, payment flexibility, and accountability for outcomes, physicians, clinicians, and health systems develop innovative approaches that improve care

[1] https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-continues-delivermeaningful-savings-and-high-quality-health-care

coordination. Accountable care has shown that aligning incentives around value rather than volume leads to better outcomes for beneficiaries and greater sustainability of Medicare.

Accountable care advances many shared policy goals, including strengthening primary care, improving beneficiary choice, expanding access in underserved and rural communities, promoting innovation, reducing unnecessary spending, and enhancing program integrity. We look forward to continuing to partner with the administration to achieve the shared goal of ensuring that every Medicare beneficiary is in a relationship accountable for cost and quality. To advance that vision, Medicare policy should focus on the following priorities.

Ensuring Sustainability. Sustaining long-term participation in accountable care requires predictable benchmarks, appropriate incentives, and policies that reward success rather than penalize it. The benchmark ratchet, where ACOs are effectively penalized for prior successful performance, remains the single greatest threat to the long-term viability of the MSSP. We appreciate the policies CMS has implemented to mitigate this issue, including the regional efficiency adjustment, prior savings adjustment, and proposed growth adjustment. However, the existing caps on benchmark adjustments continue to limit the effectiveness of these policies, particularly for organizations that have participated in accountable care for many years. As a result, physician practices and health systems increasingly seek alternative organizational arrangements or transition between models to remain financially viable. Responses like these do not reflect gaming of the program; rather, they are rational reactions to benchmark design features that make continued participation increasingly difficult for high-performing organizations. Rather than attempting to address these market responses, CMS should address the underlying benchmark methodology itself. We look forward to working with CMS on stronger and more durable solutions, including increasing benchmark adjustment caps, varying policies based on tenure in the program, and exploring longer agreement periods.

Sustainability also requires protecting ACOs from the financial effects of fraud, waste, and abuse. ACOs are often among the first entities to identify suspicious billing patterns because they bear financial accountability for total cost of care. However, current serious, anomalous, and highly suspect (SAHS) payment policies remain too limited and place the burden on ACOs to pursue reopening determinations after reconciliation has occurred. CMS should establish more streamlined and proactive mechanisms to protect ACOs from the impact of fraudulent activity. For example, while CMS deemed certain catheter expenses in 2025 met SAHS criteria, charges associated with those fraudulent providers continued into 2026 and remain in ACO expenditures. We recommend a streamlined approach in which confirmed fraudulent claims are automatically removed from ACO expenditures as well as any other claims paid into escrow, pending confirmation of fraud, that are not fully resolved at the time of ACO reconciliation.

Finally, advanced alternative payment model (APM) incentives have been critical to driving participation in accountable care and other advanced APMs. CMS should work with Congress and stakeholders to modernize participation incentives and ensure that physicians and other clinicians continue to have strong pathways into risk-bearing payment models.

Enhancing Patient Choice. Accountable care succeeds because it is built on trusted relationships between patients and their providers. However, current attribution approaches limit participation among beneficiaries who lack a usual source of care or who do not generate sufficient claims for assignment. CMS should rapidly deploy voluntary alignment in MSSP as it has proven to be a successful beneficiary engagement tool in ACO REACH.

At the same time, Medicare should continue to explore approaches that expand accountable care to additional populations. We are encouraged by the geographic alignment approach that will be tested in GEO AHEAD, but remain concerned that physicians, clinicians, and health systems participating in AHEAD states may face significant operational demands associated with implementing the primary care payment and hospital global budgets aspects of the model. CMS should consider testing GEO AHEAD in two states that are not simultaneously implementing the broader AHEAD model to ensure viability.

Finally, while accountable care produces measurable benefits for patients and taxpayers, it remains largely unknown to Medicare beneficiaries. Increasing beneficiary awareness and understanding of accountable care represents an important opportunity to strengthen patient engagement and expand participation. We would like to work together to educate beneficiaries about accountable care and the benefits of receiving care from providers participating in these models.

Accelerating Innovation. After nearly 15 years of demonstrated success, accountable care policy should move beyond incremental refinements and toward broader adoption of proven innovations. We appreciate CMS' requests for information regarding primary care capitation and specialist engagement. Capitation approaches have been successfully tested by the Innovation Center and should be prioritized for implementation within MSSP beginning in 2028. Enhanced cash flow mechanisms support care transformation by enabling organizations to invest in care management, technology, and workforce capabilities before savings are realized. Accordingly, NAACOS recommends retaining and strengthening the prepaid shared savings program.

CMS should also continue incorporating successful Innovation Center model waivers into MSSP, simplify required reporting for waivers, and create an approach for ACOs to recommend and test additional waivers across accountable care models. In addition, as CMS modernizes quality measurement, we encourage the agency to establish a digital quality measure pilot to ensure future implementation is informed by testing, operational experience, and provider feedback. Innovation should remain a defining characteristic of accountable care, supported by policies that enable organizations to test new approaches and rapidly scale those that improve value.

PHYSICIAN PAYMENT

Telehealth

Changes to the Medicare Telehealth Services List

CMS proposes to add several services to the Medicare Telehealth Services List, including new codes for clinical staff-delivered advance care planning, shared medical appointments, certain pediatric speech-language pathology services, and evaluation and management (E/M) services related to vaccine adverse effects. NAACOS supports the addition of these services to the Medicare Telehealth Services List, which helps to maintain alignment between the Medicare Telehealth Services List and codes newly added to the Physician Fee Schedule and ensures continued access to services, especially for patients who face geographic, mobility, or other barriers to accessing in-person care.

Telehealth Critical Care Consultations

As part of CY 2026 rulemaking, CMS established HCPCS codes G0508 and G0509 for telehealth consultations furnished to patients requiring critical care services and permanently removed frequency restrictions on these services. For CY 2027, CMS proposes revisions to the code descriptors to clarify the

distinction between the initial and additional consultation time associated with these services. NAACOS supports these proposed revisions and appreciates efforts to provide clarity regarding appropriate coding and billing for telehealth critical care consultations.

Teaching Physicians' Billing for Services Involving Residents and Virtual Presence
In the CY 2026 PFS final rule, CMS adopted a policy to permanently allow teaching physicians to have a virtual presence in certain teaching settings when the teaching physician, resident, and beneficiary were each in different locations. Stakeholders have since provided feedback that this policy does not address scenarios where the teaching physician or resident may already be in the same location as the beneficiary. As a result, CMS proposes to modify this policy to permit the teaching physician or resident to be in the same physical location as the beneficiary while the other participates virtually. NAACOS supports this proposed change, which is responsive to stakeholder feedback in providing additional flexibility to address this complexity.

Remote Monitoring Services

Remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) have become important tools for supporting patients outside of traditional care settings. These services can extend the reach of care teams and support ongoing management of patients between in-person encounters. These capabilities are especially important for beneficiaries in rural and other communities where access to in-person care may be limited.

In response to concerns raised by the Department of Health and Human Services' (HHS) Office of Inspector General (OIG), CMS proposes several changes to RPM and RTM policies for CY 2027, as discussed in more detail below.

Established Patient Requirement
CMS proposes to require that RTM services be furnished only to established patients, consistent with the existing requirement for RPM services. NAACOS supports this proposal and agrees with CMS that limiting RTM to established patients can help address concerns identified by the OIG regarding practices billing for remote monitoring services without a prior relationship with the patient.

Initiating Visit Requirements
CMS proposes to require practitioners reporting RPM or RTM services to furnish a separately reportable initiating visit in association with the onset of these services. Under this proposal, the visit must be initiated by the billing practitioner during a face-to-face visit where RPM or RTM is discussed. CMS states that the policy is intended to ensure that the practitioner has assessed the beneficiary to determine that remote monitoring is clinically appropriate, noting that these services "require a level of care coordination that cannot be effective without appropriate evaluation of the patient's needs."

NAACOS opposes this proposal. We are concerned that a blanket initiating visit requirement could create unnecessary burden and barriers to care in circumstances where a treating clinician already has an established relationship with the patient and has sufficient information to determine that remote monitoring is clinically appropriate. At a minimum, NAACOS recommends that CMS establish an exception for beneficiaries aligned to an ACO. Given that ACOs are accountable for both the cost and quality of care furnished to aligned beneficiaries, they are inherently structured to ensure services like RPM or RTM align with the clinical needs of the patient and are coordinated effectively. Requiring a separate initiating visit for an ACO-aligned beneficiary, where the treating clinician already has the

information necessary to determine that remote monitoring is appropriate, would be duplicative and add administrative burden without meaningfully improving care coordination or oversight.

Supervision Requirements
CMS proposes to only allow payment for RPM and RTM services furnished by clinical staff when those staff are directly employed by the billing practitioner or practice. This proposal would essentially disallow practices from contracting with third-party vendors to provide remote monitoring services.

NAACOS strongly opposes this proposal, which disregards the role that vendor partnerships can play in increasing efficiency, lowering the cost of care, and making remote monitoring a viable option. Clinically integrated vendor arrangements provide specialized expertise, clinical staffing, technology and operational infrastructure, and patient engagement capabilities that allow remote monitoring programs to scale efficiently and sustainably while preserving clinician oversight and accountability for care.

The proposed restriction would be particularly challenging for practices that do not have the scale or capacity to build an RPM or RTM program entirely in-house. This concern is especially acute for smaller practices and clinicians serving rural communities, where requiring every component of remote monitoring to be maintained internally could further limit access to care. Ultimately, the proposal could result in beneficiaries losing access to existing services, as well as having significant financial implications on practices, health systems, and ACOs that have realized more efficient staffing and reduced labor costs through remote vendor arrangements.

NAACOS understands CMS' interest in ensuring that remote monitoring services are clinically appropriate. However, prohibiting contracted clinical staffing is not the only way to address this concern. **NAACOS strongly recommends that CMS delay these requirements at least two years as it continues to work with stakeholders to develop an appropriately scoped policy that balances addressing program integrity concerns with maintaining beneficiary access and care.** There are several approaches that CMS should explore including:

- Requiring that RPM and RTM services be initiated pursuant to an order from a treating clinician;
- Integrating relevant remote monitoring information into a treating clinician's electronic medical record and documentation so the information is easily accessible to the treating care team; and,
- Establishing more robust qualifications or oversight requirements for entities supporting remote monitoring services, such as a CMS registration framework similar to that used for DMEPOS suppliers.

We would also encourage CMS to consider lessons learned from the recently launched Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, which is testing outcome-aligned payments for technology-enabled care. For example, CMS should explore outcome reporting, initially on a pay-for-reporting basis, to create greater transparency into the effectiveness of remote monitoring services. Following an appropriate testing period, CMS could evaluate whether a portion of payment should be tied to outcomes, similar to the approach being tested under ACCESS. Additionally, CMS should explore ACCESS-like requirements where vendors must have a relationship with the provider, including sharing care updates back to the referring clinician.

CMS should also consider providing greater flexibility for beneficiaries served by clinicians participating in APMs. ACOs and other total-cost-of-care entities are accountable for the cost and quality of care furnished to their populations, providing an additional safeguard against unnecessary utilization. **At a**

minimum, CMS should create an exclusion from this requirement for beneficiaries that are aligned to an APM. CMS could require a blanket exception or allow ACOs to submit their approved vendors to CMS so that billing can occur, similar to the approach used for the SNF waiver.

Evaluation and Management

E/M Visit Complexity Add-on

CMS proposes replacing the E/M complexity add-on (HCPCS code G2211) with percentage-based modifiers. Under the proposal, MOD1 would increase payment for an associated eligible E/M service by 16 percent, while MOD2 would provide a 32 percent increase for qualifying services furnished by participants or practitioners participating in MSSP, the ACO Primary Care Flex Model, and the Long-term Enhanced ACO Design (LEAD) Model. ACO participants would determine, based on the circumstances of the visit, whether MOD1, MOD2, or no modifier is appropriate. Additionally, MOD2 could be reported for beneficiaries regardless of whether the beneficiary is assigned to the ACO.

NAACOS strongly supports this proposal and appreciates CMS' recognition of the enhanced care management provided by clinicians participating in ACOs. Clinicians in ACOs make investments in care coordination, data infrastructure, population health management, quality improvement, and patient engagement that extend beyond an individual billable encounter. Recognizing these capabilities through the PFS can better align fee-for-service payment with the infrastructure and support required to deliver accountable care. Importantly, the proposal creates a direct financial incentive for clinicians to join and remain in ACOs. NAACOS has consistently urged CMS to strengthen financial and nonfinancial incentives for clinicians to participate in accountable care.

We also support allowing ACO participants to use MOD2 for services furnished to all Medicare beneficiaries they treat rather than limiting use to beneficiaries assigned to the ACO. Practices develop much of their care delivery infrastructure at the practice level, and these capabilities benefit all Medicare patients regardless of assignment status.

To maximize benefits of this policy change, we also encourage CMS to expand eligibility to other longitudinal care providers. CMS should extend the visit complexity benefit to critical access hospitals (CAHs), rural health clinics (RHCs), and federally qualified health centers (FQHCs), as G2211 was never separately payable in these settings and these clinicians often have the strongest longitudinal relationships with rural and underserved Medicare populations. Additionally, CMS should expand eligibility to include the E/M services most commonly furnished in long-term care (LTC) and nursing facility settings. While CMS expanded G2211 last year to include home/residence E/M services, this did not expand access for most beneficiaries residing in LTC settings. To address this gap, CMS should expand modifier eligibility to include the nursing facility E/M code family commonly used in LTC practice, including CPT codes 99304-99310. This change would better align payment policy with the realities of longitudinal care delivery, promote parity across care settings, and appropriately recognize the clinical complexity involved in caring for frail, high needs Medicare beneficiaries.

Request for Information: Redesigning Primary Care to Make America Healthy Again

Developing Prospective Payment in MSSP

NAACOS strongly supports developing prospective payment options within MSSP, beginning with primary care. CMS should move expeditiously to offer ACOs both primary care capitation and hybrid payment options that shift the underlying payment mechanism away from fee-for-service (FFS).

Even within accountable care, the continued reliance on FFS creates a fundamental mismatch between how care is financed and how ACOs are expected to deliver care. ACOs and participating practices are accountable for improving quality and managing total cost of care, yet many of the activities necessary to achieve those goals are not adequately supported through visit-based payment. Care coordination, chronic disease management, behavioral health integration, patient navigation, outreach, data analytics, and interventions addressing upstream drivers of health all require practices and ACOs to invest before any shared savings are realized. Prospective payment can address this cash flow challenge by providing predictable resources earlier in the performance year, when they can be used to redesign care rather than reimburse activity after it occurs.

Importantly, prospective payment does more than change the timing of Medicare payments. It gives ACOs and practices the flexibility to invest in services and capabilities that may not generate a discrete billable claim but are essential to improving outcomes and reducing avoidable utilization. If structured appropriately, prospective payment can reduce the continued dependence on visit volume and support a more comprehensive, longitudinal approach to primary care.

Evidence from CMS programs reinforces the importance of pairing strong primary care investment with accountability for total cost of care. An evaluation of the Comprehensive Primary Care Plus (CPC+) Model also found statistically significant reductions in several utilization and spending measures among practices that simultaneously participated in MSSP, including a reduction in total Medicare expenditures for Track 1 participants in the fourth program year. These findings support a broader conclusion: investments in primary care are more likely to translate into Medicare savings when they are made within an accountable care framework.

CMS has already developed and operationalized prospective payment approaches through ACO REACH and ACO Primary Care Flex (PC Flex). The agency should now use that experience to establish prospective payment options in MSSP. Doing so would create stronger parity between MSSP and LEAD, reduce unnecessary variation across CMS accountable care initiatives, and make it easier for organizations participating in more than one model to administer consistent payment arrangements. Overall, a simpler, REACH-style capitation option in MSSP would also provide broader access to prospective payment than the more restrictive PC Flex structure. However, the hybrid payment structure is best for some ACOs such as those with a large portion of FQHC participants.

Eligibility and Voluntary Participation

CMS should make primary care capitation and hybrid payment options available to all MSSP ACOs participating in a risk-bearing track. Beginning with risk-bearing ACOs strikes the appropriate balance between encouraging payment innovation and protecting the Medicare Trust Funds. ACOs accepting downside risk remain accountable for quality and total cost of care and therefore have strong incentives to use prospective payments to improve outcomes and avoid unnecessary spending. That accountability also reduces the risk of overpayment because additional primary care investment occurs within a broader financial arrangement under which the ACO bears responsibility for overall expenditures.

CMS should not impose additional eligibility restrictions based on ACO type, revenue designation, length of MSSP participation, or prior participation in an Innovation Center model. The exclusion of high-revenue ACOs from PC Flex was an arbitrary limitation that prevented many ACOs and primary care practices from participating. An ACO's organizational structure does not determine whether its practices

would benefit from more predictable primary care payment, nor does it eliminate the need to move care delivery away from a volume-based financing structure.

Many risk-bearing ACOs are already prepared to administer prospective payment. ACOs have developed relevant experience through ACO REACH, Medicare Advantage, Medicaid, and commercial contracts. Some have offered comparable arrangements to practices participating in their REACH contracts. Other ACOs may be newer to prospective payment but have the financial accountability, provider relationships, and population health infrastructure necessary to implement it. CMS should allow each eligible ACO to determine whether the option is appropriate.

Primary care practices themselves have different levels of readiness. Some are prepared to transition directly to capitation. Others would prefer a hybrid arrangement that provides predictable prospective revenue while retaining a portion of FFS payment. Still others may not be prepared to change their payment flow. Different levels of readiness may be based on practice size, ownership, available infrastructure, financial reserves, or experience with similar Medicare Advantage, Medicaid, and commercial arrangements.

For these reasons, participation must be voluntary at both the ACO and participant TIN levels. CMS should permit an ACO to elect whether to offer capitation or hybrid payment and then allow individual participant TINs to determine whether to participate. CMS should not require all primary care TINs within an ACO to adopt the same payment mechanism.

The all-TIN participation requirement was a significant barrier in PC Flex. Under that design, a TIN that did not want hybrid payment could prevent the entire ACO from participating or would have to leave the ACO. That policy gave a single practice effective veto authority over the choices of other practices and the ACO. It also made the model less workable for ACOs that contain a mix of employed and independent practices, or practices with materially different payer arrangements. TIN-level choice would allow ACOs to begin with practices that are most prepared for prospective payment, including practices already participating in similar arrangements with other payers. It would enable ACOs to test operational approaches, demonstrate value to other participant providers, and expand adoption over time without forcing practices to change their payment model prematurely. Additionally, allowing this flexibility could encourage ACOs to include participant TINs that have not historically participated in ACOs, and may not be ready for prospective payments, consistent with CMS' broader goals of expanding participation to providers with limited value-based care experience. Accordingly, CMS should not establish a minimum percentage of participant TINs that must elect prospective payment as a condition of ACO participation.

After CMS has implemented these options across all risk-bearing tracks and collected sufficient information on adoption, spending, quality, and operational performance, the agency could explore phasing prospective payment into upside-only MSSP tracks. Beginning with risk-bearing ACOs would establish clear accountability during implementation while preserving a pathway toward broader availability.

Primary Care Capitation

CMS should establish a primary care capitation option in MSSP that substantially replicates the Primary Care Capitation methodology used in ACO REACH. NAACOS supports carrying forward the REACH approach, including the defined list of primary care services subject to capitation and corresponding claims reductions.

The scope of services is an important protection for both practices and beneficiaries. Under the current REACH methodology, claims reductions apply only to services on the defined primary care service list when those services are furnished by specified primary care clinicians. Other services, including procedures outside that defined list, continue to be paid normally by Medicare. Replicating this approach in MSSP would allow CMS to shift an appropriate set of routine primary care services into capitation without inadvertently sweeping unrelated services into the payment or creating unnecessary disruption in claims payment.

Using the REACH framework would also promote alignment with LEAD and reduce the operational burden of maintaining different service definitions, claims-reduction methodologies, and payment processes across CMS models. Organizations with experience administering REACH capitation could use established systems and provider education materials, while new participants would benefit from a methodology that has already been implemented in practice.

Within CMS-established parameters, the ACO should select the appropriate capitation amount. ACOs differ in provider composition, historical primary care spending, experience with population-based payment, and the types of arrangements they administer across payers. Allowing the ACO to select an amount within a reasonable range would provide flexibility without requiring CMS to develop separate methodologies for every organizational structure. NAACOS recommends the following parameters:

- Capitation level. The approximately seven percent capitation level used in ACO REACH is adequate as a standard MSSP option. CMS should establish seven percent as the default available to participating ACOs while allowing ACOs to elect a higher or lower primary care capitation percentage within a CMS-defined range. A standard capitation amount would provide a meaningful and familiar entry point, while a range would allow for organizations to select capitation options that meet their needs, and for more advanced organizations, to move a greater share of primary care revenue away from FFS.
- Enhanced Payment. CMS should also preserve the REACH methodology's recognition that historical primary care spending may vary across ACOs. Under the current methodology, Base and Enhanced Primary Care Capitation generally may not exceed seven percent of the benchmark, but ACOs with primary care spending above that level may elect their historical base percentage plus up to two percent in Enhanced Primary Care Capitation. This feature is important because a uniform ceiling could otherwise reduce payments to ACOs that have already made substantial investments in primary care.

CMS should make capitated payments to the ACO, with the ACO responsible for establishing and administering downstream payment arrangements with participating TINs. The ACO is accountable for total cost of care and quality and is best positioned to determine how prospective resources should be allocated to support its care delivery strategy. Some ACOs may distribute most or all of the funds directly through capitated payments. Others may combine direct payments with practice incentives, shared infrastructure, centralized care management, analytics, behavioral health supports, or other programs that benefit participating practices and their beneficiaries.

The ACO-directed approach is also consistent with the need for flexibility across employment and affiliation structures. A uniform CMS payment made directly to every practice would not account for differences between employed practices, independent practices, and ACOs that provide centralized services on behalf of their participants.

ACOs electing primary care capitation should incorporate the arrangement into written agreements with participating TINs. Those agreements should describe the payment methodology, the responsibilities of the parties, and the general approach to distributing or using prospective payments. Existing MSSP participation agreements provide an appropriate vehicle for documenting arrangements that the ACO and practice have negotiated and accepted.

Primary Care Hybrid Payment

CMS should also establish a CMS-administered hybrid payment option for all risk-bearing MSSP ACOs. Although NAACOS prefers a simpler REACH-style capitation approach if CMS implements only one option, offering both capitation and hybrid payment would better reflect the diversity of ACO and practice readiness. A hybrid payment would serve as an on-ramp for practices that are not prepared to shift fully to capitation. By combining prospective payment with continued FFS reimbursement for a portion of services, hybrid payment can give practices experience managing predictable monthly cash flow while limiting the immediate financial and operational disruption of a complete transition.

CMS should build this option based on lessons from PC Flex, but it should not simply replicate the PC Flex methodology. CMS should modify the following aspects:

- Payment Guardrails. CMS should establish a payment guardrail ensuring that every participating primary care practice does not receive less under the hybrid option than it would have received through FFS. The county rate book approach disadvantages ACO practices that had already invested in primary care. Many ACOs have primary care spending above that of non-ACO practices in their counties because they have built care teams and infrastructure to support accountable care. Basing payment on a county average can therefore produce a payment reduction for the very practices that have made the greatest commitment to strengthening primary care. PC Flex provides this type of protection for FQHCs and RHCs. If the prospective primary care payment is less than actual fee reductions for those providers, they receive an additional payment for the difference. The model also provides a beneficiary-level add-on for beneficiaries receiving the plurality of their primary care from FQHCs and RHCs. Comparable protection should be extended to other primary care practices.
- Attribution. The hybrid option should build on MSSP's existing attribution methodology and should not be limited to ACOs using prospective assignment. Limiting eligibility in that manner would exclude risk-bearing ACOs that otherwise have the accountability and infrastructure needed to administer hybrid payment. For ACOs using retrospective assignment, CMS could recalculate the hybrid payment quarterly to account for new beneficiary attributions and changes in the assigned population. However, the agency must structure this adjustment process carefully. Under PC Flex, members expressed concern that funds could be recouped by CMS in the month following a quarterly assignment run while the reprocessing and payment of affected claims could take significantly longer. That timing gap could disrupt ACO operations and create the precise cash flow instability that prospective payment is intended to solve. CMS should therefore minimize retroactive recoupments, provide advance notice of material payment adjustments, and coordinate any recoupment with claims reprocessing so participating practices are not left without either the prospective payment or the corresponding FFS revenue. Quarterly recalculation should function as a manageable true-up based on updated attribution, not as a recurring source of unpredictable payment disruption.
- Enhanced Payment. Under the CMS-administered hybrid option, any enhanced payment should be benchmark-based and established by CMS. In contrast to the ACO-selected enhanced amount under primary care capitation, a nationally administered hybrid option would benefit from a common methodology. The enhanced payment should remain optional, however. An

ACO should be able to elect the base hybrid payment without being required to accept an enhanced payment that will be reconciled against its benchmark.

Data and Technical Assistance

Prospective payment cannot succeed if ACOs and practices lack the data needed to understand payment calculations, manage their attributed populations, and evaluate performance. CMS should provide timely and actionable data throughout the performance year to ACOs and participating practices. REACH ACOs electing Primary Care Capitation receive beneficiary alignment data, claims data, risk-adjustment data, aggregated payment data, aggregated benchmark data, and quality performance scoring data during the performance year. CMS should provide MSSP ACOs electing capitation or hybrid payment with comparable information, ideally monthly.

CMS should also provide greater granularity where necessary for practice-level administration. ACO-level aggregated payment and benchmark reports do not allow an individual primary care practice to assess its financial targets, reconcile its expected payments, or understand how beneficiary changes affect its prospective revenue. CMS should make relevant payment and performance information available at the practice or beneficiary level, subject to appropriate data-use protections.

The timing of these data is as important as their content. ACOs and practices need information before making participation decisions, throughout the performance year to manage care and payment, and before any payment adjustment or recoupment occurs. Providing payment specifications or rate data after election deadlines, as occurred with the PC Flex county rate book, prevents meaningful financial planning and discourages participation.

CMS should supplement the data with technical assistance focused on operationalizing population-based payment. Participating organizations may need support interpreting payment files, understanding claims reductions, forecasting cash flow, developing practice agreements, and reconciling beneficiary-level payment information. Technical assistance will be particularly important for smaller, independent, rural, and safety-net practices that may have less administrative infrastructure but would benefit substantially from more predictable payment.

Reporting and Program Oversight

CMS should rely on transparency, existing ACO accountability, and targeted oversight rather than establishing prescriptive spending requirements. We anticipate that reporting will be an adequate guardrail during the early years of implementation.

CMS could require ACOs to report quarterly or annually on:

- The ACO's general approach to primary care capitation or hybrid payment;
- The percentage of participant TINs electing each payment option;
- The percentage of prospective funds distributed to practices as capitated or hybrid payments; and
- The percentage retained or deployed by the ACO for other primary care investments, incentives, shared services, infrastructure, or programs.

NAACOS does not have a strong preference between quarterly and annual reporting. CMS should select the least burdensome frequency that provides sufficient information to monitor adoption and understand how ACOs are using the payment flexibility. The agency should not require transaction-level reporting or an accounting of every expenditure.

CMS should not establish a minimum percentage of prospective payment that must flow directly to primary care practices. Such a requirement would fail to recognize the varied ways ACOs support their participant providers. An ACO may furnish centralized care management, analytics, technology, patient navigation, behavioral health support, or other shared services rather than distributing the full amount as cash payments. Those investments can provide direct value to participating practices and beneficiaries even though the funds do not appear as a downstream capitation payment.

CMS likewise should not require a minimum percentage of beneficiaries to receive care management. Care management is one valuable use of prospective funding, but it is not the only one. Conditioning eligibility on a single intervention would arbitrarily constrain care redesign and could encourage ACOs to document a required activity rather than invest in the services most responsive to local needs.
The more appropriate guardrails are already built into MSSP. Risk-bearing ACOs are accountable for quality and total cost of care. If an ACO fails to use prospective payments effectively, the consequences should be reflected in its quality and financial performance. ACOs will also document payment arrangements through written participant agreements and report basic information to CMS.

CMS should collect and publicly report aggregate adoption information, including the number and characteristics of participating ACOs and TINs, election of capitation versus hybrid options, and changes in adoption over time. This information would allow CMS and stakeholders to evaluate whether the policy is reaching a variety of practice types and identify barriers requiring future modification.
CMS should monitor implementation for several years before considering thresholds or additional requirements. If concerns arise regarding a specific ACO's payment practices, CMS should use existing program authorities, including corrective action plans, to address the individual organization rather than imposing new requirements on all participants.

Using Enhanced Payments to Encourage Adoption
CMS should use the treatment of enhanced payments in benchmark reconciliation as an affirmative incentive for prospective payment adoption. If enhanced payments are fully and immediately reconciled against an ACO's benchmark, organizations may be reluctant to use the funds for long-term investments because they must preserve reserves against the possibility that the payment will be recouped.
NAACOS does not recommend a single exemption amount at this stage. CMS should instead offer meaningful forms of reconciliation relief at implementation and modify the policy over time based on adoption and performance.

For example, CMS could exempt enhanced payments directed to rural providers, independent practices, FQHCs, RHCs, or other safety-net providers from benchmark reconciliation. Smaller and independent practices may begin with fewer resources and may benefit particularly from upfront funding that can be invested without creating an immediate repayment liability. CMS could also allow enhanced payments to be reconciled over multiple performance years. Investments in staffing, technology, behavioral health integration, and care management may require more than one year to generate measurable changes in utilization and total cost of care. A multi-year approach would better align reconciliation with the period over which care transformation is expected to produce results.

The agency should begin with broadly available incentives designed to overcome the uncertainty associated with adopting a new payment method. CMS can then evaluate which ACO and practice types elect prospective payment, where adoption remains limited, how enhanced funds are used, and whether participation varies by geography, ownership, rurality, or practice size. Based on this

experience, CMS could refine or target exemptions while avoiding an overly restrictive initial policy that suppresses adoption before the approach has had a meaningful opportunity to develop.

Supporting Beneficiaries Planning for Future Medical Decisions

Advance Care Planning (ACP) Services

CMS proposes creating two new HCPCS codes (GACP1 and GACP2) to describe Advance Care Planning (ACP) services provided by clinical staff under direct supervision of the billing practitioner. NAACOS supports this change, which promotes team-based care approaches commonly employed by ACOs. We encourage CMS to continue to explore opportunities to increase utilization of ACP services, which support beneficiary choice and engagement, shared decision making, and care coordination. For example, CMS should consider expanding general supervision requirements for ACP services to include offsite and virtual supervision, in recognition of team-based care approaches.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes recognizing Diabetes Self-Management Training and Medical Nutrition Therapy as qualified preventive services covered as stand-alone billable visits under the Rural Health Clinic (RHC) benefit, aligning RHC policies more closely with FQHC and physician-office payment policies. NAACOS supports this proposal. Providing appropriate payment for these services can better support chronic disease prevention and management and improve access for Medicare beneficiaries served by rural providers.

CMS also proposes codifying the continued abeyance of the RHC/FQHC mental health visit in-person requirements through December 31, 2027. NAACOS supports this change and continued flexibility for access to behavioral health services.

Ambulatory Specialty Model (ASM)

CMS previously finalized the Ambulatory Specialty Model (ASM) to begin January 1, 2027. NAACOS continues to remain concerned about requiring specialists who are actively engaged in an ACO to also participate in ASM. **NAACOS strongly recommends that all clinicians in an ACO or other total cost of care APM should be excluded from ASM.** At a minimum, providers that have QP/Partial QP status should be excluded from the model or allowed to voluntarily opt-in to ASM. NAACOS remains concerned that requiring specialists who are in an ACO or other total cost of care APM to participate in ASM will exponentially increase administrative burden, create duplicative reporting requirements, and more importantly, unintentionally discourage specialists from remaining in and joining Advanced APM arrangements.

ASM Eligibility

CMS previously finalized the participant eligibility criteria for ASM, including a requirement that clinicians have at least 20 cohort-specific episodes attributed under the episode-based cost measure (EBCM) during the two years preceding the performance year. CMS also finalized a policy under which, once a clinician meets the participant eligibility criteria and is selected to participate in ASM, the clinician remains an ASM participant for the duration of the model test period. However, an ASM participant may not meet the participant eligibility criteria in every performance year. In years in which the criteria are not met, the participant would not be subject to ASM performance assessment,

reporting, scoring, or payment adjustment requirements and would instead be subject to MIPS requirements, if applicable.

NAACOS is concerned that participation status may fluctuate from year to year for clinicians with lower volumes, resulting in burden and confusion for participants. NAACOS recommends that CMS raise the participant eligibility threshold to at least 100 attributed episodes during the two-year baseline period and require a minimum of 50 attributed episodes during a performance year for each condition cohort (heart failure and low back pain). This will support the goal of identifying clinicians with sufficient patient volume to meaningfully participate in the model. Increasing beneficiary thresholds would reduce the influence of high-cost outliers for clinicians with a low volume of cases and protect them from financial outcomes driven by random variation.

Redesignated Specialty Types
CMS proposes a process for participants in the ASM heart failure cohort to redesignate their subspecialty type and receive an exception from ASM requirements. This proposal is intended to address instances in which the ASM methodology used to identify eligible specialists may capture cardiac subspecialists whom CMS did not intend to include in the heart failure cohort, which was designed to focus on cardiologists. NAACOS supports this proposed revision.

Data Submissions
CMS clarifies that ASM participants in small practices may submit ASM quality measure data at either the group or individual level, and proposes to allow ASM participants to submit data for Improvement Activities performance category at either level. NAACOS supports these general revisions. We also encourage CMS to allow all ASM participants to report either individually or at the group/TIN level across all four performance domains, which is consistent with the existing approach used in MIPS.

Quality Measurement
CMS proposes to add the "MRI Lumbar Spine for Low Back Pain (modified for ASM)" measure. **NAACOS does not support inclusion of this measure.** We urge CMS to publicly release the measure specifications, testing results, and other supporting information necessary for clinicians and stakeholders to evaluate whether the revised measure appropriately balances the need for reliable and valid performance assessment with the opportunity for meaningful improvement. This measure should be postponed until this information is made available.

NAACOS supports CMS' proposal to remove the "Functional Status Change for Patients with Low Back Impairments" measure (MIPS Q220) since the measure steward has indicated that it no longer intends to maintain the measure. NAACOS also supports replacing it with the "Functional Outcome Assessment" measure (MIPS Q182).

CMS proposes to establish a voluntary data submission opportunity and scoring incentive for ASM participants to report patient-reported outcome (PRO) data. **NAACOS does not support requiring PRO measures for performance assessment or accountability purposes until there has been sufficient testing and validation** to demonstrate that the measures are reliable, comparable across providers and patient populations, actionable for quality improvement, and can be collected without imposing undue administrative burden on participants. However, **NAACOS supports CMS' proposal to provide a quality performance category scoring incentive for the voluntary submission of PRO data.**

Across the cost and quality measures, we urge CMS to provide participants with timely data and transparency into specialist-specific benchmarking, episode cost benchmarking, and post-acute utilization patterns. These insights are essential for understanding performance variation, identifying key cost drivers, and developing targeted strategies to improve quality and efficiency.

CMS should also establish and communicate performance thresholds before the start of each performance year, ensuring participants clearly understand program expectations and have the ability to monitor performance, assess progress, and make meaningful operational adjustments throughout the performance period.

Rural Scoring Adjustment
CMS proposes awarding five points to the final score of ASM participants in rural areas. Additionally, CMS notes rural participants remain eligible for the small practice or solo practitioner adjustment and the complex patient adjustment.

NAACOS appreciates CMS' recognition that rural participants face unique structural challenges, as well as its proposal to mitigate those challenges through a five-point rural adjustment. **However, NAACOS recommends that CMS exclude rural clinicians from ASM participation altogether.** We are concerned that performance will be based on small sample sizes that are subject to random variation as most rural clinicians have low volumes. As we discuss above, raising the volume threshold will also protect these clinicians. Additionally, clinicians in rural areas face other challenges, including workforce shortages, limited resources, and interoperability challenges that hinder care coordination and performance.

Collaborative Care Arrangement (CCA) Requirements
CMS proposes several updates to the CCA provisions to improve implementation and better align CCA requirements. In particular, NAACOS supports CMS allowing one or more ASM participants in the same TIN to enter a CCA with the same primary care practice, to help streamline contracting and reduce administrative burden for both specialists and primary care practices. CMS should clarify and provide guidance on how participation changes could impact ongoing CCAs, participant eligibility, and related program obligations. CMS should also provide additional education around applicability of fraud and abuse waivers and other model protections when participants become ineligible, are terminated from the model, or are otherwise not eligible for a given performance year.

MEDICARE SHARED SAVINGS PROGRAM

Beneficiary Assignment

Policies to Increase Beneficiary Assignment
CMS proposes two technical modifications to its beneficiary assignment processes, effective beginning PY 2028, as part of its goal to increase beneficiary assignment to ACOs. These include:

1. ***Modifying the claims-based assignment methodology***, in all three steps, to exclude from calculations the allowed charges for primary care services delivered by an ACO professional but billed through a non-ACO TIN. This would also apply to charges billed through non-ACO CCNs. CMS notes that this would not affect competition between TINs enrolled in different ACOs but would advantage ACO-enrolled TINs and CCNs over non-ACO TINs and CCNs in assignment calculations. Additionally, this change would not affect assignment calculations when an ACO

professional participates in multiple ACOs and would have no impact on beneficiary expenditure calculations.

2. ***Expanding the assignment eligibility criteria*** to mirror the definition of an "assignable beneficiary," which would apply to both claims-based and voluntary assignment eligibility criteria and the prospective assignment exclusion criteria. The proposed new criteria would include beneficiaries with at least one month of Parts A and B enrollment and no Medicare group enrollment during that same month in the assignment window. Effectively, this change would allow assignment of beneficiaries who switch from Medicare Advantage (MA) back to traditional Medicare during the assignment window.

While NAACOS conceptually agrees with these changes, which will increase assignment to ACOs, we urge CMS to conduct further analysis on the impacts of these policy changes and implement guardrails to mitigate unintended consequences before finalizing. ACO members serving predominantly high needs, homebound, and institutionalized beneficiaries have raised potential concerns with these policies. Beneficiaries often transition out of MA in order to elect the Medicare hospice benefit, which could lead to unusual enrollment patterns for ACOs that include hospice. Additionally, the risk adjustment model in MSSP was not designed to project these types of changes mid-year. This oversight could lead to newly added beneficiaries not being adequately captured in risk adjustment.

In CMS' analyses, the agency notes that both of these policy changes will result in relatively small increases in assignment to MSSP overall (by about one percent and 2.5 percent, respectively). However, CMS also notes that a small segment of ACOs will be disproportionately affected and that the beneficiaries added under these policy changes tend to be higher cost and higher risk than the current assigned beneficiary population. Given the potential negative impact and the lack of specificity around the effect this would have on certain types of ACOs, geographic areas, and patient populations, we encourage CMS to conduct further analyses and ensure the policies do not harm ACOs serving vulnerable populations in the program (e.g., complex and seriously ill populations) prior to implementation.

Definition of Primary Care Services Used in Assignment

CMS proposes to update the definition of primary care services used to determine claims-based assignment by adding codes for:

- *Screening, Brief Intervention, and Referral to Treatment* (G2011, G0396, G0397)
- *Vaccine Adverse Effects Management* (GADV1), which is an add-on payment for diagnosis and management of suspected vaccine adverse reaction in conjunction with an E/M visit – *if finalized for coding and payment*
- *Advance Care Planning* (GACP1, GACP2), which reflect ACP services furnished by clinical staff under direct supervision of the billing practitioner – *if finalized for coding and payment*

The code descriptors for these services largely mirror those of codes already included in the definition of primary care services used in assignment and therefore NAACOS supports their addition.

<u>Quality</u>

NAACOS applauds CMS for proposing critical changes to ACO quality requirements, which will reduce burden in the program, more fairly and accurately assess provided care, align quality measurement with approaches for improving outcomes, and better support ACOs and their practices in the transition to digital quality measurement approaches. Many of these proposals are directly responsive to NAACOS member requests, including a permanent extension of the MIPS CQM reporting option and the MIPS CQM reporting incentive, new options for ACOs to report on only assigned beneficiaries, solutions on data completeness challenges for ACOs, and maintenance of the current quality measure set to minimize disruptions as ACOs prepare for digital quality measurement. Additionally, NAACOS supports CMS' goal to shift to Fast Healthcare Interoperability Resources (FHIR) for all of its quality reporting programs. We look forward to working with CMS to ensure a smooth transition.

MIPS CQM Collection Type and Reporting Incentive

NAACOS supports CMS' proposal to retain the MIPS CQM reporting option for ACOs for Performance Year (PY) 2027 and subsequent years. While CMS notes it anticipates sunsetting MIPS CQMs as an option for MSSP once it fully transitions to FHIR-based reporting, it does not propose an end date in this rule. This creates needed stability for ACOs. NAACOS has encouraged CMS to retain all current reporting options through the transition to FHIR-based quality reporting, and we are appreciative of this proposal. It will greatly reduce burden for ACOs that have invested time and resources in the MIPS CQM reporting pathway. This option is essential for organizations serving high proportions of complex and institutionalized beneficiaries because they face unique challenges in meeting MSSP quality requirements. Absent this change, many of these organizations may have to exit the program. We encourage CMS to finalize this policy as proposed.

We are also very supportive of the proposal to extend the MIPS CQM reporting incentive through PY 2027 and subsequent years. This policy recognizes scoring challenges when reporting on all payers and all patients and will support the needs of ACOs serving complex, homebound, and facility-based beneficiaries. While we do not support requiring all payer/all patient reporting, this reporting incentive is key to meeting CMS' desired goals and ensuring more appropriate comparisons for ACOs electing this reporting pathway. NAACOS encourages CMS to finalize this policy as proposed, and to retain the MIPS CQM reporting incentive for all payer/all patient reporting for as long as the MIPS CQM reporting pathway is available.

Scoring Medicare CQMs

In these proposals, CMS effectively permanently implements the use of flat benchmarks to score Medicare CQMs beginning with PY 2026. NAACOS is very supportive of these proposals, which we have previously recommended as a more transparent, predictable, and fair quality measure benchmarking approach for reporting options that only include ACOs. CMS proposes applying flat benchmarks retroactively for PY 2026 to the Medicare CQMs for *Controlling High Blood Pressure, Diabetes: Glycemic Status Greater Than 9%,* and *Preventive Care and Screening: Screening for Depression and Follow-up Plan* and applying flat benchmarks to all Medicare CQMs for PY 2027 and subsequent years. Under current policies, the *Breast Cancer Screening* and *Colorectal Cancer Screening* Medicare CQMs will already be scored using flat benchmark for PY 2026. As CMS notes in the rule, the current decile-based benchmarking policies under MIPS could skew performance when measures are only or predominantly reported by ACOs due to higher overall performance being distributed across deciles. We appreciate CMS acknowledging the challenges with MIPS benchmarking policies when applied to measures exclusively reported by ACOs. We are also encouraged by CMS proposing this change retroactively for PY 2026 reporting, which will take place in early 2027, as this will increase transparency and reduce burden for ACOs reporting Medicare CQMs in the upcoming reporting period.

Data Completeness Requirement

CMS addresses unique challenges ACOs face in meeting MIPS data completeness requirements when data access issues arise. These proposals are directly responsive to situations NAACOS has raised in which data cannot be accessed by the ACO, thus jeopardizing the ACO's ability to successfully report quality measures. **We applaud CMS for proposing to apply this change retroactively for PY 2026. This will greatly alleviate burden and confusion in the upcoming quality reporting period. We strongly encourage CMS to finalize these proposals with the modifications outlined below to ensure the policy achieves its intended impact.**

CMS proposes to:

- Allow ACOs to exclude, based on applicable circumstances, one or more TIN(s) from the ACO's quality submission beginning PY 2026.
- After the application of TIN exclusions, the ACO's submission would need to include participant TINs that represent at least 95% of the ACO's assigned beneficiaries prior to the application of measure specifications. We encourage CMS to monitor whether this threshold remains sufficient as implementation progresses, especially when measures shift to a fully digital environment.
- Finally, MIPS data completeness for ACOs would be calculated based on the remaining denominator. Effectively, the resulting population would be considered 100% of your denominator and MIPS data completeness would be calculated based on missing numerator data.

Proposed applicable exclusions would cover:

(1) unforeseen circumstances outside the ACO's control (such as a practice closing unexpectedly mid-year),
(2) the participant TIN uses a Certified EHR Technology (CEHRT) product that is designed for specialty use and does not support one or more measure(s) included in the APP Plus quality measure set, or
(3) other circumstances as determined by CMS.

CMS would provide a new aggregate report to ACOs with the beneficiary-TIN level data necessary for ACOs to determine how many beneficiaries would be represented by the TINs they plan to report on. CMS plans to share a preview report with ACOs during the third quarter of 2026, and a definitive final report during fourth quarter 4 of 2026, if finalized. We are supportive of CMS' intent to provide transparent and definitive data to ACOs to support implementation of these new flexibilities. CMS also proposes that only beneficiaries who have at least one eligible primary care encounter during the performance year would be included in the numerator calculation, but the denominator would include the ACO's total number of assigned beneficiaries.

First, NAACOS encourages CMS to expand exclusion category (2) to "the ACO participant TIN has a CEHRT product that does not support the measure(s) in the APP Plus quality measure set." Limiting it to only include "specialty focused" EHR products does not address the experiences of non-specialist-focused EHR vendors who refuse to support specific measures required for ACOs.

Second, NAACOS encourages CMS to more clearly define what "other circumstances as determined by CMS" would include and to establish a standard, transparent process for ACOs to submit exclusions under this category. NAACOS has received many questions from ACO members since the publication of

the proposed rule as to what would be considered acceptable under this category. We urge CMS to provide more clarity. By creating a process for ACOs to submit exclusions, CMS would retain the flexibility to address nuanced situations that could not be predicted beforehand. CMS should also consider applying Promoting Interoperability (PI) exclusions and hardship exemptions to the data completeness flexibility, as challenges with CEHRT can impede a TIN's ability to produce the necessary files for electronic clinical quality measure (eCQM) reporting.

Finally, **we strongly urge CMS to reconsider its approach for the numerator calculation of the 95 percent threshold for assigned beneficiaries. This will significantly disadvantage ACOs under prospective assignment** since the assignment window does not align with the performance year. Under this proposal, prospective ACOs could have fewer than 95 percent of assigned beneficiaries included in their submission without excluding any TINs, thus making the policy unusable. This approach would also disadvantage ACOs that have more voluntarily aligned beneficiaries, who could be assigned to an ACO without having a qualifying primary care encounter during the performance year. To create fairness in the policy across types of ACOs in the program, CMS should simplify the calculation of assigned beneficiaries for this policy by utilizing the ACO's final assigned beneficiary list as the starting population for both the numerator and the denominator. This is also a more sensible approach because ACOs are still financially accountable for assigned beneficiaries, regardless of whether or not they receive a qualifying primary care service during the performance year.

Medicare eCQMs Collection Type

We applaud CMS' proposal to create a new reporting type, "Medicare eCQMs," to enable eCQM reporting on only ACO-assigned patients. This option solves many of the challenges that can arise when ACOs are required to report on all patient/all payer populations, often due to a practice's payer mix, including a dramatic increase in the volume of data to be reported. As NAACOS has previously commented, it is inappropriate to assess ACOs on patients the ACO is not financially accountable for and does not receive data on. The goal of quality reporting is to reflect the quality of care delivered by ACOs, and all payer/all patient reporting skews the data in groups with many specialists. Many patients seen in specialty practices may have no primary care relationship with the ACO, thus limiting the ACO's ability to access quality measure data for those patients.

CMS also proposes that Medicare eCQMs would be scored using flat benchmarks and that this option would continue to be available through the transition to FHIR-based quality measurement. We appreciate the consistency of using flat benchmarks across both reporting options that are exclusively reported by ACOs and the stability of implementing this option without an end date.

To ensure this option is practically available for ACOs, we encourage CMS to work with the vendor community to ensure that CEHRT products support Medicare eCQM reporting. Without the ability to filter QRDA I files by ACO-attributed patients, ACOs will still be required to extract large volumes of data before narrowing down to the attributed population. This adds significant burden. Initial feedback from ACOs is that most vendors cannot currently support this reporting option. We look forward to working with CMS and the vendor community to ensure this option is meaningfully available when it is implemented in PY 2027. NAACOS supports these proposals and encourages CMS to finalize them as proposed.

Definition of a Beneficiary Eligible for Medicare CQMs

ACOs have expressed challenges with identifying which Medicare fee-for-service beneficiaries must be included in Medicare CQM reporting based on the current definition. NAACOS applauds CMS' proposal

to revise the definition of a beneficiary eligible for Medicare CQMs to limit the population to only ACO-assigned patients. We have long raised concerns with assessing ACOs' quality based on patients not managed by the ACO for purposes of determining shared savings and losses. These proposals are directly responsive to ACOs' concerns. We also appreciate CMS making explicitly clear that the Medicare CQM reporting option will remain available through the transition to FHIR-based reporting. NAACOS supports these proposals and encourages CMS to finalize them beginning with PY 2026 rather than waiting until 2027.

Another change CMS should implement to improve the Medicare CQM reporting pathway would be to provide additional beneficiary information in the Medicare CQM file format, similar to what is currently included in the QALR quarterly beneficiary files. ACOs frequently report a high rate of patient mismatching between the Medicare CQM list and the EHR, requiring manual intervention to match patients' data. The current Medicare CQM file includes MBI, first name, last name, sex, and date of birth. By adding beneficiaries' address (street, city, state, zip code), CMS could increase the accuracy of the quality data file submissions and reduce the likelihood of patient matching errors.

Scoring Policy for Excluded Measures

Noting an increase in the total number of measures in the APP Plus measure set since this policy was first introduced, CMS is proposing to modify the measure suppression policy. Under the proposed policy, an ACO would only receive the higher of its score or the quality performance standard if the ACO's quality category score is calculated on less than five measures for a given PY (i.e., when four or more measures are excluded), and would no longer apply when measures lack a benchmark. While we conceptually agree with CMS' rationale related to the increase in measures in the set, we have concerns with the possibility of an ACO being assessed on only two ACO-submitted measures. As proposed, you could have three of five ACO-reported measures excluded and be scored based on the two administrative claims measures, CAHPS, and the two remaining reported measures. ACO members have expressed challenges with the administrative claims measures and CAHPS for MIPS given ACOs do not receive performance data on them during the performance year to conduct improvement efforts in a timely fashion. Without timely or actionable data on three of the five measures assessed, we do not believe it would be appropriate to assess an ACO's quality score in the above scenario.

The current measure suppression policy awards an ACO the higher of its score or the MSSP quality performance standard if any measure(s) are excluded, lack a benchmark, or the total measure achievement points available are reduced. **To align with the current policy, a minimum of three ACO-reported (i.e., clinical) measures should be included to assess an ACO's performance**. We strongly encourage CMS to modify this proposal such that the measure suppression policy would apply when three or more of the ACO-reported measures in the APP Plus quality measure set are excluded for a given performance year.

Request for Information: FHIR-Based Digital Quality Measurement in CMS Quality Programs

NAACOS continues to support the vision of a digital quality measurement (dQM) framework that supports multiple use cases. Our members seek to move to a quality measurement approach that leverages interoperable data sources that are seamlessly integrated and available at the point of care, increasing efficiency, reducing administrative burden, and empowering patients and providers to make informed care decisions. Transforming care delivery and improving quality are cornerstones of accountable care. ACOs and providers in accountable care regularly leverage data and technology by integrating claims and clinical data to enhance clinical outcomes through innovative solutions and population health management. We believe that the data used for quality measurement should be a

byproduct of care delivery – data that accurately and comprehensively represents the quality provided by ACOs and their clinicians – and shifting to FHIR-based dQMs moves us closer toward that goal.

We appreciate CMS moving away from its previously suggested approach of shifting to FHIR-based electronic clinical quality measures (eCQMs), which are limited in their sole reliance on data from EHRs, and instead prioritizing FHIR-based dQMs, which allow practices to access data from numerous sources. While CMS acknowledges in this RFI the additional complexities and challenges that ACOs face in adopting FHIR-based dQMs, we do not believe the suggested two-year transition period reflects those complexities or the current state of industry readiness.

NAACOS conducted a survey of ACOs in July and August 2026 to collect specific feedback on the benefits of and barriers to adopting FHIR-based dQMs, as well as incentives and technical assistance that are needed to move the industry forward. A total of 81 organizations representing more than 240 unique CMS ACO contracts responded. Results show that ACOs see the benefits of this transition, including less manual reporting, more automated and integrated data sharing, improved data availability and timeliness, and better monitoring of performance across participant TINs. Survey responses also highlight the consequences of the shift from Web Interface to current reporting options, including the removal of more than 500 practices and nearly 3,000 clinicians from the responding ACOs. Most of the respondents noted that removals were due to practices' inability to produce the required QRDA files for eCQM reporting.

We are committed to CMS' goal of growing and strengthening the ACO program, which is why this FHIR dQM transition must be strategic and thoughtful. Our comments below incorporate key considerations to ensure this transition is successful, drawing on lessons learned from ACOs' experiences with current quality reporting pathways and FHIR adoption. We look forward to continuing collaboration with CMS on solutions that support the future of tech-enabled health care.

Transition Period Must Recognize Industry Readiness and Practical Realities

CMS does not address industry readiness, which continues to be a significant limitation. Certification criteria for vendors have not been adequately updated to ensure that certified health IT products can support FHIR-based reporting. Even in the current state, vendor requirements are insufficient to support ACO quality reporting requirements. Many of our members that have attempted to use FHIR for quality data reporting have been unsuccessful, largely due to vendor limitations and lack of support for Bulk FHIR, which is critical given the volume of data reported by many ACOs. While we recognize that CMS does not have authority to regulate the technology industry to force this shift, it is inappropriate to require ACOs to shift to reporting pathways that are not technologically feasible in the current state, especially when financially accountable for the results. To date, CMS and ONC have not clearly articulated a pathway for how certification and FHIR-based dQMs will work together.

The vast majority of ACOs have multiple EHR products, which are often not interoperable with one another. In the 2026 survey, 62 percent of respondents reported using more than five distinct EHR systems and 26 percent reported using more than 15. When looking at instances of EHRs used by participant TINs in the ACO, 74 percent reported using more than 5 and 37 percent reported using more than 25, creating significant headwinds for interoperability efforts. Further exacerbating this challenge is that ACOs do not have control over which EHR and other health IT products their participating practices use. More than 40 percent of survey respondents had to remove practices from their ACO due to the practices' EHRs being incompatible with eCQM reporting. Most of these were small, independent, and specialty practices. Without sufficiently requiring vendors to support FHIR-based reporting prior to

implementing this transition, we will see more practices dropped from ACOs as a result of this shift. This is directly counter to CMS' goals of including more small, independent practices in ACOs and engaging specialists in accountable care.

The health care enterprise needs to understand the extent to which CMS has been in conversations with EHR vendors, other health IT vendors, registries, and third-party intermediaries involved in quality reporting to prepare for this transition. Beyond transparency, CMS should take a more active role in convening stakeholders and bring together vendors, ACOs, providers, and others to identify implementation challenges and refine these policies collaboratively. Significant burden and costs on individual practices can be avoided by ensuring all stakeholders are aligned prior to this transition. The vendor community has expressed that not every clinical concept as it's represented now fits well into the FHIR standard. We note that in public comments responding to CMS' draft FHIR dQMs earlier this year, technology vendors expressed concerns with transitioning to FHIR dQMs in the current state. For example, Epic's public comments included the following remark on how more work is needed to utilize FHIR data for quality measures:

"A clear example is the Encounter resource. The FHIR specification itself acknowledges substantial variance in how organizations represent encounters. For instance, an ED visit that transitions to an inpatient floor stay may appear as a single encounter in a FHIR implementation. Quality measures, however, require separate encounters for distinct QDM Encounter Datatypes. Aligning FHIR data to measure specifications will therefore require development work beyond what existing APIs provide. Similar considerations apply to procedures and other data classes."

Even if the technology for FHIR-based reporting is available by PY 2028, a two-year transition period is not sufficient given the diversity of ACOs and their practices. This timeline assumes that all providers will have the capability to adopt FHIR-based quality reporting starting in PY 2028. We do not believe this is a reasonable assumption based on current reported readiness. When asked about familiarity with and readiness for FHIR implementation, 82 percent reported being unprepared for the transition to FHIR dQMs, with 54 percent of those being unprepared for any FHIR implementation. Two years is an insufficient runway for providers to adopt necessary workflow changes and meaningful data capture prior to mandatory FHIR-based reporting. Additionally, having optional reporting for two years followed by mandatory reporting is not a true transition period when many organizations will not have the option to implement FHIR dQMs during the optional years due to the numerous barriers preventing adoption. When asked about challenges and barriers to transitioning to FHIR dQMs, some of the top barriers reported include the cost of investment and ability to sustain participation within current model incentives, vendor timelines and capabilities, lack of internal technical capabilities, and lack of adequate CMS/ONC guidance and support. Some respondents noted that it is impossible to adequately assess the barriers and challenges with currently available information.

CMS' suggested approach would require organizations to maintain two separate reporting mechanisms, stating, "For APP Plus measures that do not have FHIR-based dQM specifications following the transition period, Shared Savings Program ACOs would continue to use applicable existing reporting mechanisms until FHIR-based dQM options are developed and adopted through future rulemaking." This adds significant burden, including costs to individual practices and clinicians, particularly for smaller, rural, and independent practices that lack the bandwidth, staff, and resources to maintain separate reporting methods. This would also contribute to provider burden and confusion given FHIR-based measures will require different documentation and workflows compared to currently available measure types.

The continued misalignment of measure specifications across reporting options (e.g., MIPS CQMs vs eCQMs) creates further challenges in preparing organizations for the shift to FHIR-based dQMs. The practical reality is that many organizations cannot report eCQMs in the current environment, and the FHIR dQM specifications CMS has introduced are essentially eCQM specifications translated into the FHIR standard, creating additional challenges for organizations that are already most challenged by interoperability limitations.

Based on the challenges outlined above and survey responses from ACOs, a minimum of three to five years is needed, from the time FHIR-based reporting becomes an available option (i.e., not from current state), before implementing required FHIR dQM reporting. Even after FHIR dQM reporting becomes mandatory, there should be no financial penalties or public reporting of these data until results have been tested and validated for at least five years. Many of the initial differences in performance scores and associated benchmarks will be due to differences in data sources rather than true variations in the quality of care provided, making them inappropriate for public reporting and determination of shared savings and losses or other financial adjustments.

The Importance of Testing and Validation Before Imposing Requirements

We support this transition, but CMS cannot, within the context of these programs, implement FHIR dQMs as a test case without compromising the integrity of the quality reporting programs as a result. The consequences of imposing such requirements without appropriate testing and validation in a voluntary program will undoubtedly result in practices and ACOs exiting the program. This is in direct contrast to CMS' stated goal to grow the program and include more small, rural, and independent providers. It is disappointing that CMS makes no note of any testing period to ensure that FHIR-based reporting is feasible, consistent, and accurate before imposing financial penalties on ACOs.

We continue to urge CMS to pilot and scale approaches for FHIR-based quality measurement with ACOs. NAACOS has a handful of members who are more advanced in this space and committed to the transition to FHIR who have been attempting to test FHIR-based quality measures for CMS with limited success. This experience shows that it will take significantly longer for ACOs that have not yet begun this journey. These early adopters of FHIR also tend to be larger, well-resourced organizations and their experiences and readiness should not be assumed to translate to all ACOs in the program. As noted, 83 percent of respondents reported being currently unprepared for the transition to FHIR dQMs, and 100 percent of respondents said it is "very important" or "critical" that CMS provide a dedicated testing and validation period before FHIR-based dQM results count towards ACO quality performance, with 93 percent of those saying it is critical. Nearly 38 percent of respondents noted their organizations would be interested in participating in a pilot program testing FHIR-based quality reporting for ACOs, while 37 percent said they were unsure. Those that were not interested largely reported this was due to lack of bandwidth and resources to meaningfully participate in a pilot.

Value-based care entities develop relationships with practices, hospitals, physicians and other clinicians, and vendors to support population health. As such, ACOs are uniquely positioned to partner with CMS in piloting and scaling approaches for FHIR-based dQMs. ACOs that are at the forefront of the digital quality transition could be tapped to help identify vendors that are successfully working to implement FHIR capabilities to participate in a pilot. This approach should include a representative group of ACOs to ensure that organizations with various compositions, sizes, and geographic footprints can succeed in digital quality measurement. CMS should offer incentives for ACOs to participate in a pilot by providing relief from other ACO quality reporting obligations (i.e., achieving the quality performance standard).

Because ACOs integrate data from multiple sources and across the continuum of care, they are arguably the most complex implementation environment for FHIR-based dQMs. By demonstrating success in an ACO pilot, the health care ecosystem will be able to save time and money during this transition as many of the costs and challenges with requirements will be identified, refined, and possibly resolved prior to scaling. In addition, it would enable CMS to determine what additional certification requirements may be needed and what additional products and solutions should be enabled to facilitate digital quality measurement. Ultimately, we believe that this work will increase the confidence of all health care providers and CMS that FHIR-based dQMs can be successfully implemented in other health care settings. While piloting and scaling FHIR-based reporting before implementing requirements will increase the overall timeline to transition, these steps are necessary to ensure the integrity and validity of quality reporting and value-based programs, preserve participation, and actualize the true potential benefits of a FHIR-based quality reporting framework.

Necessary Practice Education, Incentives, and Technical Assistance

Education and technical assistance on this shift should not be assumed to be provided to practices by vendors, it should be coming from CMS and their subcontractors. When asked about confidence in vendor readiness to support FHIR dQMs, a plurality (31 percent) of respondents were unsure, highlighting the lack of information in this space. Another 39 percent of respondents were either somewhat or completely unsure of their vendors' ability to support the transition. CMS must increase transparency in this space to ensure the transition will be successful. The existence of a FHIR dQM specification is a small piece of this overall pathway and there needs to be a significant education and outreach component to this, including the full spectrum of participants from individual clinicians and small practices, FQHCs and RHCs, and large, complex organizations like health systems and ACOs. For example, CMS could create an implementation toolkit that is provided to individual practices and includes education on what FHIR is, what it means for your practice, what you need to ask your vendors to ensure they can handle this shift, etc. Such educational materials should be tailored to various types of entities to ensure all participants are prepared for their role in this transition.

Additional high-value technical assistance suggested by ACOs included FHIR implementation guides and tutorials, vendor engagement, enforcement, and coordination support, measure-by-measure dQM implementation support, and data mapping and terminology standardization assistance.

Beyond education and outreach, appropriate incentives and flexibilities are needed. CMS should provide incentives for ACOs to encourage early adoption during the transition period and ensure that ACOs will not be at risk for losing maximum shared savings. CMS should shift to pay for reporting for quality during this transition as it will be difficult to determine whether performance scores from dQMs are due to the completeness and validity of the data versus true differences in quality. As mentioned previously, ACOs should not have to expend unnecessary resources and funds to support simultaneously reporting multiple collection types (e.g., Medicare CQMs and dQMs).

When asked what flexibilities and incentives would most help the ACO successfully transition to FHIR-based dQM reporting, survey respondents demonstrated a strong preference for phasing in performance-based assessment (i.e., pay for reporting) without duplicate reporting requirements, including financial incentives for practices to fund necessary infrastructure upgrades, limiting required reporting to ACO-attributed patients, and lowering the quality performance standard during the initial period of performance-based assessment.

NAACOS plans to publish a detailed report of these survey results in the coming weeks, which should provide valuable data to CMS on the current state of readiness and what education and technical assistance should be prioritized. Our members are eager to collaborate with CMS and other stakeholders to ensure the transition to FHIR dQMs achieves its goals.

Certified Electronic Health Record Technology (CEHRT) Use

CMS proposes a major overhaul of CEHRT use requirements for MSSP ACOs. First, CMS will repeal the requirement for all MSSP ACOs to report the MIPS Promoting Interoperability (PI) category beginning in PY 2027. Importantly, CMS has also announced it will exercise its enforcement discretion for this requirement in PY 2026. Similar to PY 2025, MSSP ACOs that do not report PI will not face compliance actions. NAACOS applauds this move, as we have raised serious challenges with requiring all ACOs to report MIPS PI, particularly for ACOs in Advanced APM tracks that are supposed to be exempt from MIPS requirements. **NAACOS supports these proposals and encourages CMS to finalize them, with some modifications, as described below.**

To replace the current PI requirement for ACOs, CMS proposes MSSP ACOs may select between three pathways for demonstrating CEHRT use. These proposals reflect NAACOS' recommendations for a more flexible, attestation-based approach that meets ACOs and their participating practices where they are. ACOs may demonstrate CEHRT use via at least one of the following:

1. **Completely report at least one ACO-reported quality measure as an eCQM or Medicare eCQM, if finalized**. ACOs electing this option would not need to complete any additional reporting or attestation, as CMS would already receive this information through ACOs' quality submissions. We support this option and encourage CMS to finalize it as proposed.

2. **Attest to ACO's use of FHIR capabilities to support reporting of at least one ACO-reported measure using CEHRT.** Importantly, this is an ACO-level attestation and would not require each individual participant TIN in the ACO to leverage FHIR. Because CMS cannot discern how ACOs collect data for MIPS CQMs and Medicare CQMs, ACOs electing this option would complete an attestation in the Data Hub of the ACO-MS following its quality submission to satisfy the requirement. We support this option and encourage CMS to finalize it as proposed. We also urge CMS to continue to provide education and technical assistance to ACOs and their participating providers to support broad adoption of FHIR-based data exchange.

3. **Select and attest to at least one of the MSSP CEHRT use metrics: Electronic Prescribing, Health Information Exchange (HIE) Bi-Directional Exchange, or ACO Provider to Patient Exchange.** The ACO would attest via the Data Hub of the ACO-MS that at least one clinician within each ACO participant TIN without an available exclusion satisfied the selected measure. Proposed applicable exclusions are:
    a. Meeting the definition of "special status" including: ASC-based, facility-based, hospital-based, non-patient facing, located in a Health Professional Shortage Area (HPSA), rural area. CMS proposes that the small practice designation would not qualify as an applicable exclusion.
    b. Facing hardship circumstance(s) that would qualify for a MIPS PI hardship exception request but would not require submitting a MIPS PI hardship exception application.

Overall, NAACOS supports these options, which will reduce burden compared to current requirements and will encourage adoption of FHIR. **However, we disagree with CMS' proposal to remove the small practice designation as an applicable exclusion for option three**. This option is otherwise aligned with MIPS PI exclusion categories and, importantly, this exclusion is currently available for ACOs. The proposed rule will be finalized after ACOs will have had to make participation decisions for PY 2027, jeopardizing ACOs' ability to comply based on their inclusion of small practices. The removal of the designation is also counter to CMS' intent to increase small and independent practice participation in ACOs. We urge CMS to preserve this flexibility for small practices so that CEHRT reporting requirements do not become a barrier to their continued participation in accountable care. Additionally, we encourage CMS to modify the facility-based exclusion to apply to clinicians who deliver services in nursing facilities and assisted living facilities. While these clinicians document clinical care in the facility's CEHRT, they cannot access PI data as they cannot bifurcate the data by TIN. These challenges are like those of other facility-based clinicians included in the current special status, and this should be extended to other facility types.

Finally, CMS proposes revising public reporting requirements for CEHRT use such that ACOs must report on which of the three allowable CEHRT options they selected for a given performance year. CMS notes ACOs should retain documentation associated with the option elected. CMS also clarifies that these requirements have no impact on current MSSP quality or MIPS PI scoring policies. We support the proposed public reporting requirement and appreciate the included clarifications.

RFI: Applying Electronic Prior Authorization Measures to Shared Savings Program ACOs

CMS seeks feedback on potentially requiring the use of specified FHIR-enabled health information technology (IT) modules to complete at least one electronic prior authorization request and determination for a medical item or service as an option for meeting MSSP CEHRT use requirements beginning in CY 2028. **NAACOS supports making this an optional pathway as it could create additional flexibility for ACOs to meet the CEHRT requirements**.

CMS also seeks feedback on creating a new ACO-specific electronic prior authorization measure to require use of specific FHIR-enabled health IT modules within CEHRT to complete at least one prior authorization request and determination for at least one prescription drug during the performance period, beginning with the CY 2028 performance year. **NAACOS opposes creating a separate FHIR-based requirement. Any new FHIR requirements in MSSP should be aligned with the broader transition to FHIR-based requirements across CMS programs, including quality reporting.**

NAACOS has repeatedly raised concerns regarding the feasibility and timing of transitions to FHIR-based reporting, particularly for ACOs, which include multiple TINs operating across multiple EHR systems with different functionalities and readiness. CMS must ensure that the timeline aligns with updates to certification requirements, as well as the transition to FHIR-based digital quality measure reporting, and that both vendors and providers can implement the necessary functionalities in a non-burdensome, non-cost prohibitive manner. Prior to moving forward with any new requirements, CMS should use an incremental approach that first permits voluntary adoption, tests technical feasibility, identifies operational challenges, and gives vendors and providers sufficient implementation time before establishing mandatory ACO requirements.

Benchmarks and Financial Methodology

Cap on Adjustments to the Historical Benchmark

CMS states that its financial methodology proposals are intended to "grow the number of health care providers and beneficiaries in accountable care relationships and grow savings to the Medicare Trust Funds while improving the quality of care for beneficiaries" (91 FR 44067). While we concur with CMS' stated goal, we remain concerned that the current and proposed policies do not go far enough to maintain long-term program participants.

CMS originally put in place historical benchmark adjustments to mitigate benchmark ratchet. Under current policy, the combined five percent cap on upward benchmark adjustments effectively limits an ACO's ability to realize the full value of efficiencies it generates through participation in MSSP over time. Many ACO investments in care coordination, health information technology, beneficiary outreach, and other population health initiatives, are non-billable services that create a growing disconnect between an ACO's true operating cost and its historical benchmark. As ACOs become more successful and efficient, the benchmark becomes progressively less reflective of the resources required to sustain those improvements, let alone expand them.

Accordingly, **NAACOS calls on CMS to increase the caps on the historical benchmark.** At a minimum, we request that CMS explore policies to ensure that long-term participants are not hampered by the benchmark ratchet. For example, CMS could consider tiering or prorating the cap based on length of participation across ACO programs and longer agreement periods, similar to LEAD.

ACOs that have remained in the program across multiple agreement periods have already demonstrated sustained savings and have fewer remaining opportunities to generate new reductions in spending. Allowing a higher cap for these long-term participants would better preserve incentives for continued participation, investment in care transformation, and expansion.

CMS proposes risk adjusting the five percent cap on upward adjustments to the historical benchmark to make it a more accurate reflection of the complexity of an ACO's patient population. **NAACOS supports this proposal and urges CMS to add protections to ensure that this policy does not negatively impact ACOs.** That is, CMS should not risk adjust the five percent cap below 1.0 and should explicitly state this in any finalized historical benchmark risk adjustment policy.

Sharing Rate Under Level E

NAACOS appreciates and supports the proposal to increase the BASIC Track Level E shared savings rate from 50 percent to 60 percent, while maintaining the 50 percent shared losses rate, to smooth ACOs' transition to the ENHANCED track and reverse decreased participation, starting with performance years beginning on or after January 1, 2027. We agree this change will provide BASIC Level E ACOs with more incentive to remain in the track longer, resulting in additional time and experience to build the infrastructure needed to manage greater downside risk and succeed under the ENHANCED track in the future.

Regional Adjustment

NAACOS strongly opposes CMS' proposal to reduce the ENHANCED track's positive regional adjustment maximum weight from 50 percent to 35 percent for lower-spending ACOs. We also strongly object to the rationale CMS provides in support of this proposal. The agency's justification is fundamentally flawed, relies primarily on descriptive observations rather than rigorous analysis, and fails to reflect the realities facing ACOs and value-based care participants.

First, CMS asserts that larger regional adjustments may be contributing to higher observed gross savings in ENHANCED track ACOs and therefore may be partly driving performance rather than reflecting genuine efficiency gains. However, this finding is both expected and consistent with the purpose of the policy. The Regional Efficiency Adjustment was specifically designed to reward ACOs that achieve spending levels below those of their regional peers and to make benchmarks "more independent of [an ACO's] historical expenditures and more reflective of FFS spending in its region" (81 FR 37951). Evidence that efficient, long-standing ACOs disproportionately benefit from the Regional Efficiency Adjustment does not demonstrate a policy failure. Rather, it demonstrates that the policy is functioning as intended. Additionally, NAACOS rejects CMS' assertion that ACOs "passively earn shared savings at the highest sharing rate by solely relying on baseline efficiency through the regional adjustment to the benchmark" (91 FR 44254). ACOs serve changing beneficiary populations and must continually invest in care transformation to maintain regional efficiency. Moreover, regional efficiency is not maintained for populations in traditional Medicare that are not in ACOs, pointing to broader intervention in ACOs.

If CMS believes positive regional adjustments are driving performance rather than genuine efficiency gains, the agency should first conduct a more rigorous analysis demonstrating statistically significant causal evidence of this effect. Absent stronger evidence, CMS has not justified reversing a longstanding policy that has been central to MSSP benchmark design for existing ACO participants and one of their key levers for growth and success in the program.

For example, CMS could conduct cause-and-effect and simulation testing on current and higher caps, accounting for a range of ACO characteristics (i.e., longevity and number of agreement periods — across CMS ACO programs and models — not only MSSP; size; urban vs. rural; physician vs. hospital or health-system led; and patient medical complexity).[2] CMS should use these analyses to identify whether particular combinations of benchmark policies disproportionately disadvantage ACOs that have demonstrated sustained efficiency or made substantial investments in care transformation. Benchmark policies should allow ACOs to maintain and continue to improve upon their success.

We also urge CMS to examine whether ACO participation generates spillover effects that reduce spending among non-ACO-attributed beneficiaries in the same market. Recent research provides positive evidence of market-level spillover, including changes in outpatient facility and physician spending.[3, 4] If ACO-driven improvements contribute to lower regional spending over time, including outside of ACOs, we encourage CMS to assess whether spillover effects — which are positive for patient care — create an additional ratchet effect for successful ACOs.

Second, CMS notes that the financial impact of regional adjustments has increased over time. This observation should not be surprising. Most ACOs benefiting from positive regional adjustments are long-standing MSSP participants that have invested for years in care coordination, population health

[2] Publication by the Institute for Accountable Care (IAC) under peer review. IAC completed a 10-year simulation of MSSP payment reconciliation using CY 2024 rules, found that increasing the positive Regional Efficiency Adjustment cap from 5% to 7% increased total simulated savings by 8.5%, while increasing the shared savings add-back from 50% to 65%, increased total savings by 0.3%.

[3] Cohen KR, Vabson B, Podulka J. et al. Medicare Risk Arrangement and Use and Outcomes Among Physician Groups. *JAMA Network Open.* 2025;8(1)e2456074. doi:10.1001/jamanetworkopen.2024.56074.

[4] Vabson B, Cohen K, Ameli O, et al. Potential Spillover Effects on Traditional Medicare When Physicians Bear Medicare Advantage Risk. *American Journal of Managed Care.* Published online February 26, 2025. doi:10.37765/ajmc.2025.89686

management, and other delivery system reforms that have allowed them to become more efficient than regional peers. CMS originally projected that the Regional Efficiency Adjustment would encourage participation and strengthen incentives for care management investments (81 FR 37951). The growing impact of the adjustment reflects the cumulative success of those investments and is not evidence that the policy should be curtailed.

Third, CMS suggests that increasing the Prior Savings Adjustment could partially offset reductions in the Regional Efficiency Adjustment for some ACOs. We disagree. The Prior Savings Adjustment and Regional Efficiency Adjustment serve distinct purposes and are not interchangeable. The Regional Efficiency Adjustment reflects the long-term, sustained performance for ACOs across numerous contracts in the areas they serve, while the Prior Savings Adjustment is a benchmark ratchet mitigator between contracts. CMS' own analysis demonstrates that many ACOs would continue to experience net benchmark reductions because the proposed increase in the Prior Savings Adjustment does not fully replace the value of the forgone Regional Efficiency Adjustment. Therefore, the proposed increase in the Prior Savings Adjustment (discussed in detail below) cannot justify weakening an established benchmark protection relied upon by efficient ACOs. By reducing the positive regional adjustment for efficient ACOs, CMS would effectively increase the benchmark ratchet effect that the Regional Efficiency Adjustment was originally intended to mitigate.

Fourth, if CMS' concern relates to newly formed ACOs or newly participating TINs receiving favorable regional adjustments before demonstrating performance, we recommend CMS develop a more targeted policy for those entities, such as considering ACOs' and Participant TINs' length of time in the program.

Finally, we note that decreasing the Regional Efficiency Adjustment would create a significant disconnect between MSSP and the LEAD Model. CMS adopted the 50 percent positive regional adjustment in LEAD based on the successful application of the policy in MSSP. Changing the Regional Efficiency Adjustment is not a feature that LEAD was intended to test. Therefore, reducing the adjustment in MSSP's ENHANCED risk track while maintaining the full adjustment in LEAD creates inconsistent incentives across CMS accountable care programs and may encourage efficient MSSP ACOs to consider participation in LEAD instead.

Prior Savings Adjustment

CMS proposes to increase the Prior Savings Adjustment by increasing the scaling factor from 50 percent to 75 percent. NAACOS supports this change, because an increase would — to a small extent — help mitigate benchmark ratcheting, reward ACOs for generating and sustaining Medicare savings, preserve incentives for continued investment in care transformation, and promote long-term participation in accountable care. We note, however, that while we support the increase, it does not go far enough to offset the proposed Regional Efficiency Adjustment modification, if finalized. As discussed above, the current benchmark cap is insufficient for ACOs who have participated in the program long-term. Similarly, CMS should explore increasing the scaling factor for the Prior Savings Adjustment.

Additionally, NAACOS recommends that CMS expand the Prior Savings Adjustment to account for prior savings in all ACO models (REACH, LEAD and future ACO models). Under current rules, the Prior Savings Adjustment only applies to ACOs with previous MSSP experience and does not account for prior savings ACOs generated in the REACH. While this already impacts some current ACOs (e.g., an ACO that participated in REACH 2023-2025 and started in MSSP in 2026), this also means ACOs concluding participation in the REACH model when it ends December 31, 2026 will not benefit from the Prior Savings Adjustment at all. We believe the Prior Savings Adjustment should serve as tool to mitigate the

impact of the benchmark ratchet for all participants, regardless of which ACO models they have historically participated. Accounting for prior savings across all models would be consistent with the approach CMS has proposed for the growth adjustment.

Growth Adjustment

NAACOS appreciates and supports, with modifications, CMS' proposal to introduce a growth adjustment designed to reward ACOs for recruiting ACO professionals who have not participated in MSSP, REACH, LEAD, or another CMS-designated shared savings initiative during the preceding five years and who bring new beneficiaries into an ACO. As proposed, CMS would measure qualifying beneficiary growth relative to Benchmark Year 3, calculate a growth adjustment, and add that amount to the applicable benchmark adjustment (i.e., the regional adjustment or Prior Savings Adjustment), subject to the overall cap on positive benchmark adjustments.

We support the inclusion of a growth adjustment but believe most ACOs will not benefit from it as proposed for two main reasons. First, it is too restrictive. CMS should consider removing the provision that the newly assigned beneficiaries must be specific to new ACO professionals. Second, as noted above, many ACOs are already reaching the five percent benchmark adjustment cap, which diminishes the incentive. As we discuss above, CMS should raise the cap on benchmark adjustments.

Accountable Care Prospective Trend (ACPT)

CMS originally adopted the ACPT to address the benchmark ratchet by allowing benchmarks to reflect projected spending growth rather than solely realized spending. While well intentioned, the ACPT has had the unintended consequence of lowering benchmarks when spending projections substantially underestimate actual Medicare spending growth. **In 2024, ACPT projection errors resulted in an estimated $154 million reduction in ACO revenue, and in 2025, the ACPT was projected to cost accountable care physicians and other clinicians more than $700 million.**[5]

CMS appropriately used its existing authority to reduce the weight of the ACPT in 2024 in response to these errors, but that approach provides only temporary relief. The proposed guardrails offer a more durable and predictable solution by limiting the extent to which prospective projections can diverge from realized spending growth, providing ACOs with greater certainty as they make long-term participation and investment decisions.

NAACOS applauds CMS for proposing guardrails to the ACPT and strongly encourages finalizing the policies below as proposed:

- Implement a guardrail that would not allow the modified USPCC cumulative growth rate to be:
  - More than one percent below or 1.5 percent above the corresponding observed cumulative growth rate for agreement periods beginning on or after January 1, 2027.
  - More than 1.0 percentage points below the observed cumulative growth rate for agreement periods beginning on or after January 1, 2024 and before January 1, 2027, beginning with the PY 2025 reconciliation.
- Change the ACPT from agreement period-specific to performance-year specific modified USPCC annualized growth rates.

[5] Modernize ACOs. *ACPT Overview.* April 2026. Available at: ACPT Overview. Accessed September 1, 2026.

These policies will create more predictable benchmarks and avoid penalizing ACOs for trend projection errors. Calculating and providing modified USPCC annualized growth rates closer and specific to the given PY is a step toward improving accuracy of the ACPT. Using the same modified USPCC annualized growth rates for a given PY, applied to all ACOs regardless of their agreement period start date, would also create consistency and fairness across agreement period cohorts. Additionally, we appreciate that the upper guardrail is above the lower guardrail, allowing benchmarks to grow over time and meeting the original intent of the ACPT.

CMS notes that finalizing the proposal to apply the lower guardrail retroactively would delay the PY 2025 financial results to November 2026 and shared savings payments to December 2026 to allow the proposed guardrails to be applied retroactively. While we understand the need to delay for those affected by the ACPT, **we request CMS not delay the PY 2025 reconciliation release to ACOs in agreement periods that started prior to Jan 1, 2024, who are not affected by the ACPT guardrail.** We also ask that in the future CMS consider issuing provisional reconciliations and reports on schedule while conducting the final reconciliation. Delays in reconciliation impact physician and other clinician compensation and investments in activities that drive outcomes and support population health.

Beneficiary Engagement

Part B Cost Sharing

NAACOS strongly supports CMS' proposal to allow eligible MSSP ACOs to reduce or eliminate certain Medicare Part B cost sharing when the support is reasonably related to specified clinical goals and other program requirements are met. NAACOS has long advocated for tailored Part B cost-sharing support to be available in MSSP because the existing Beneficiary Incentive Program established by Congress is too restrictive and costly for many ACOs to implement. Cost-sharing flexibility can give ACOs an additional tool to support beneficiary adherence to treatment, follow-up care, and chronic disease management while addressing financial barriers that may prevent them from receiving recommended services.

NAACOS also continues to recommend that MSSP participants be provided **with access to additional waivers successfully tested in Innovation Center models.** The current set of MSSP waivers has not kept pace with the tools available through other ACO models, such as REACH or LEAD. ACOs taking on greater financial accountability should have greater flexibility to meet beneficiaries' needs, including MSSP ACOs in higher risk tracks. These participants would benefit from additional waivers, such as a post-discharge home visit waiver and a care management home visit waiver. Additionally, CMS should consider waiving the statutory restrictions on Annual Wellness Visit scheduling, allowing AWVs to be scheduled and provided once a year at any time during a calendar year. The 12-month timeline results in arbitrary barriers to care and is implemented differently at the discretion of the MACs. Most Medicare Advantage plans already cover one AWV per calendar year, so practices must run two frequency standards across a single Medicare panel. This causes confusion, scheduling challenges, and uncompensated care. A single calendar-year standard would remove the administrative split, match how beneficiaries understand the annual benefit, and still limit the benefit to one visit per year. Completed AWVs anchor advance care planning, cognitive screening, and closure of preventive care gaps.

Prepaid Shared Savings Option

NAACOS opposes the proposal to discontinue the prepaid shared savings option following the PY 2027 cohort, with payments for PY 2026 and PY 2027 cohorts, and ceasing in 2028. We strongly recommend

that CMS maintain the prepaid shared savings option and modify it to encourage greater participation. The prepaid shared savings option is an important tool to address cash flow challenges and support investments in care transformation, particularly for organizations with limited access to capital. CMS itself acknowledges that the program's guardrails on the use and reporting of prepaid shared savings significantly limited participation.

Rather than eliminating the option due to low uptake, **we urge CMS to address the barriers by providing greater flexibility in the allowable use of funds, enabling ACOs to access the option outside of agreement renewal periods, accelerating payment timing so resources are available earlier in the performance year, and simplifying application, reporting, monitoring, and compliance requirements.** CMS should focus on maintaining appropriate repayment protections while reducing unnecessary administrative burden. As CMS seeks to expand MSSP participation and attract new organizations to accountable care, maintaining and improving this option will help reduce financial barriers to participation and support organizations that cannot afford to wait until annual reconciliation to receive shared savings payments. We recommend the following changes to the program to increase uptake.

- **Establishing a more flexible election process.** ACOs should be permitted to elect the prepaid shared savings prior to the start of each performance year rather than only at renewal. ACO capital needs can change from year to year due to participant TIN changes and external market factors.
- **Broadening allowable use standards.** CMS should allow ACOs to deploy funds flexibly in support of their care transformation strategies, including investments in care management, clinical staffing, health information technology, data analytics, beneficiary engagement, behavioral health integration, and infrastructure. CMS should avoid rigid spending categories and percentage requirements that fail to reflect differences in ACO structure, patient populations, and local care delivery needs. ACOs should be permitted to submit concise, high-level spending plans; report expenditures by broad category rather than at the transaction level (unless suspicious activity is identified); and leverage existing MSSP reporting and compliance processes whenever possible.
- **Improving payment timing.** Prepaid shared savings are most valuable when they are available as ACOs incur investment costs. CMS should issue the first payment early enough in the performance year to support hiring, contracting, technology implementation, and other startup or expansion activities. CMS should also publish a predictable payment schedule and provide advance notice and clear explanations of any changes to quarterly payment amounts.

Advance Investment Payments

NAACOS supports the proposed changes to the methodology for calculating advance investment payments (AIPs), beginning in Performance Year 2028. These include removing the Area Deprivation Index (ADI) from the methodology, adding rurality as a criterion, and providing a flat payment amount for assigned beneficiaries who do not otherwise qualify based on rurality, low-income subsidy status, or dual eligibility.

NAACOS has previously raised concerns that use of ADI can inadvertently exclude underserved beneficiaries living in high-cost geographic areas. Additionally, we appreciate CMS' recognition that adding a criterion related to rurality may better capture access-related challenges that are not fully reflected through LIS or dual-eligibility status.

We also support providing a base payment for assigned beneficiaries who do not meet one of the social-risk or rural criteria. ACOs require upfront resources to build care-management programs, data capabilities, beneficiary engagement activities, and other population-health infrastructure that benefits

their broader patient population. NAACOS has continued to encourage CMS to assess opportunities to expand access to AIPs, recognizing that many ACOs may have limited access to capital even when existing CMS classifications do not fully capture their financial constraints.

Definition of Experience with Performance-Based Risk

NAACOS supports CMS' proposal to modify the definition of an entity "experienced with performance-based risk Medicare ACO initiatives" to exclude TINs that did not have a written agreement to participate in an applicable ACO. The proposal addresses circumstances in which legacy TIN or CCN arrangements associated with Innovation Center models can affect an MSSP experience determination, even though the entity itself did not agree to participate in the ACO. Experience with performance-based risk should reflect an organization's actual historical participation in an applicable risk arrangement. Treating an entity as experienced solely because of legacy billing can inappropriately limit an ACO's ability to participate in the BASIC Track glide path.

Beneficiary Notification Requirements

NAACOS strongly supports CMS' proposals to establish a clear May 30 annual deadline for ACOs to furnish the standard written beneficiary notice and eliminate the follow-up communication requirement. NAACOS has specifically requested these changes to reduce the administrative burden and operational complexity associated with the beneficiary notification requirements. A single annual deadline will allow ACOs and participating practices to develop more consistent workflows rather than placing responsibility on frontline practices to coordinate rolling deadlines, determined by individual beneficiary visits. Eliminating the follow-up communication requirement will similarly reduce burden and remove an element of the current policy that has created operational challenges.

Additionally, NAACOS recommends that CMS clarify in the final rule that, for ACOs that have elected preliminary prospective assignment with retrospective reconciliation, beneficiaries added to the assignment list after the May 30 deadline must be notified by following performance year's May 30 deadline.

While these proposals represent significant improvements, NAACOS encourages CMS to continue its broader work to improve beneficiary engagement in accountable care. NAACOS and the Health Care Transformation Task Force previously convened ACOs and patient and consumer advocates to develop joint recommendations promoting a shift away from a standardized form-letter approach and toward more tailored beneficiary education and engagement. We welcome the opportunity to continue discussions with CMS on these opportunities to improve beneficiary engagement.

Request for Information: Specialty Care in MSSP

CMS seeks stakeholder feedback on opportunities to better integrate specialty care into MSSP and strengthen incentives for specialists to participate in accountable care arrangements. Specifically, CMS invites actionable, evidence-based recommendations on strategies to enhance meaningful engagement; improve CMS-delivered tools and support; refine attribution and benchmarking methodologies; advance specialist performance measurement; expand waiver flexibilities; and reduce ACO and clinician burden.

Meaningful Engagement

CMS should build on existing ACO infrastructure and specialist expertise to integrate specialty care into accountable care arrangements and strengthen accountability for total cost of care (TCOC). ACOs and

their specialist collaborators have a deep understanding of their patient populations, local provider networks, referral patterns, and care delivery challenges. ACOs are best positioned to design and implement specialty care engagement strategies that address the needs of their beneficiaries and communities. Many ACOs already engage specialists across Medicare fee-for-service, Medicare Advantage, Medicaid, and other value-based care arrangements. CMS should build on these existing efforts and help align incentives across these populations.

To promote collaboration across the care continuum, payment models should foster stronger partnerships between primary care clinicians and specialists through aligned incentives, coordinated care planning, effective information and data sharing, and clear care accountability throughout the patient journey.

However, existing CMS policies and program requirements have often limited meaningful specialist participation in value-based care. To strengthen collaboration and specialist integration, CMS should first address these policy and operational barriers, establishing a stronger foundation for participation.

CMS should address policies that inadvertently discourage specialist participation in accountable care arrangements. Current QP threshold policies can create disincentives for ACOs to include specialists in VBC arrangements because QP determinations are based on the proportion of payments or patients attributed through an Advanced APM. Adding specialists to an Advanced APM can lower QP thresholds and make it more difficult for organizations and clinicians to meet them. As a result, current policies inadvertently penalize APMs for being inclusive of care across the continuum in its structure.

CMS should also ensure that Advanced APM incentives support specialist adoption of value-based care by exploring pathways to allow specialists to count qualifying downstream risk arrangements toward QP eligibility and Advanced APM participation determinations. Many specialists are held accountable for cost and quality performance through downstream risk arrangements, yet those activities often are not recognized for QP eligibility. CMS should explore pathways to provide credit for qualifying downstream risk arrangements, including those that span multiple payers, to be consistent with MACRA's objective of assessing QP status across payers.

CMS should eliminate the distinction between high-revenue and low-revenue ACOs. This policy creates unintended disincentives and barriers to specialist participation and discourages inclusion of hospitals and other providers in ACOs. In particular, the inclusion of specialists can cause an ACO to be classified as high-revenue, which may result in the loss of key program flexibilities and incentives, such as access to prepaid shared savings and other supports designed to encourage participation in accountable care.

CMS-Delivered Tools and Support

CMS can support specialist engagement in ACOs with tools and infrastructure necessary for success. This includes improving interoperability and providing actionable, specialty-specific data that enables practices to integrate specialty care, identify care opportunities, manage utilization, and coordinate services in real time across care settings.

Specifically, CMS should provide actionable, clinically meaningful specialty-specific data that enables ACOs and specialists to evaluate outcomes, complications, utilization, resource use, and care variation. Data should extend beyond the attributed ACO populations to include a view into broader Medicare performance, providing ACOs and specialists with a clear line of sight into cost, utilization, and

quality across care settings. CMS should also promote greater data consistency across programs and support access to comprehensive spending information, including inpatient, procedural, ambulatory, post-acute, and prescription drug costs, alongside measures of adherence to evidence-based, guideline-directed care.

CMS should also improve the accuracy, timeliness, format, sample size, and standardization of data feeds to strengthen stakeholder confidence and encourage broader use. Interest in shadow bundles has been tempered by concerns regarding target price accuracy and statistical reliability. Inconsistencies within the data files create challenges for accurate analysis and performance evaluation. For example, episodes may indicate that a skilled nursing facility (SNF) admission occurred, while corresponding detailed SNF files do not contain a matching admission record. Such discrepancies undermine confidence in the data and make it difficult for organizations to validate findings and target opportunities. Improving access to timely, actionable specialty care data will strengthen care coordination, support more informed clinical decision making, and reduce the administrative burden associated with fragmented reporting and information-sharing systems.

These capabilities are particularly important for rural and smaller specialty practices, which often operate with limited referral networks and fewer resources to support value-based care transformation. Enhancing access to data and improving interoperability can help ensure these practices are able to meaningfully participate in accountable care arrangements and succeed under VBC payment models.

CMS should consider developing other actionable data and technology tools to support specialist engagement and performance improvement. This could include specialty-focused quality and performance dashboards that provide timely insights into complication rates, readmissions, episode costs, target price performance, and real-time care transition information. CMS should also expand tools that support chronic disease management, enhanced referral management capabilities, including referral loop closure, adherence to evidence-based care pathways, and ensuring successful movement of patients to the most appropriate post-acute, community-based, or home-based care settings. CMS should consider investing in technical assistance and streamline quality reporting and administrative requirements to reduce burden and support sustained participation in VBC.

CMS should prioritize updating waiver flexibilities in current program policies as a tool to better support specialist engagement and care redesign. Waivers made available to MSSP ACOs have been limited to date, hampering innovation in the permanent program. Further, arduous documentation and implementation requirements to utilize waivers have hindered their use. CMS should implement all Innovation Center waivers in MSSP and simplify required reporting for waiver implementation and use. CMS should also provide clear guidance to ACOs and specialists to ensure appropriate use of these protections. Going forward, CMS could consider providing additional waiver flexibilities, including the ability to select specific beneficiary subpopulations for which to implement waivers. This would allow use of enhanced care coordination and specialty engagement where these services can have the greatest impact. CMS should also allow a process for APM participants to recommend and test new waivers.

Attribution, Assignment Modifications, and Benchmarking

Current benchmarking approaches may not adequately account for the higher-acuity, clinically complex populations managed by many specialists. This can create disincentives for participation and limit opportunities for meaningful accountability. CMS can improve engagement in the current ACO models

by ensuring attribution methods and benchmarking accurately reflect the complexity of patients served by specialists.

CMS should maintain primary care as the foundation of beneficiary attribution while creating opportunities for specialists to participate meaningfully in accountability arrangements and share responsibility for patient outcomes.

First, CMS should adopt an attribution approach similar to that used in the REACH, under which ACOs identify the non-physician practitioners (NPPs) that should contribute to beneficiary alignment. Attribution methodologies that automatically include services furnished by NPPs in specialty practices can result in beneficiary alignment that does not accurately reflect ongoing primary care relationships or clinical accountability. Without a mechanism to distinguish between NPPs practicing in primary care versus specialty care settings, allowed charges for care delivered by NPPs in specialty settings following an acute event outweigh allowed charges for primary care. This results in a high-cost beneficiary being temporarily attributed to an ACO without a primary care relationship and therefore not being attributed the following year. Organizations that tend to employ more NPPs in specialty settings, such as academic medical centers and large multispecialty practices, are particularly disadvantaged by this issue.

Second, voluntary attribution can allow beneficiaries with longitudinal relationships with specialists or other clinicians participating in the ACO to align with an ACO. This approach helps create parity with the LEAD model and recognizes longitudinal relationships beyond primary care.

Finally, we encourage CMS to test and evaluate attribution approaches for certain specialties paired with benchmarking and risk adjustment methodologies that reflect the populations served by those specialties. The REACH model demonstrated that developing a benchmark approach beyond the Medicare enrollment categories was successful in bringing in new populations to accountable care, improving outcomes, and lowering costs. CMS should bring this approach into MSSP and build on it by identifying other patient populations that may benefit from targeted benchmarks and attribution.

Certain specialty practices that have longitudinal relationships with patients may be best suited for these approaches. For example, CMS could build on the lessons learned from Oncology Care Model (OCM), Enhancing Oncology Model (EOM), and Comprehensive Kidney Care Contracting (CKCC) Model by incorporating approaches for those patient populations into ACOs in addition to offering them as separate models. Within this approach, CMS could better account for high-cost therapies and drugs that are typically received by these populations. In particular, CMS could mitigate the impact of high-cost Part B drugs and emerging therapies on performance calculations by including a methodology similar to the novel therapy adjustment mechanisms previously incorporated into oncology payment models. Without these types of appropriate adjustments for typical expenditures, benchmarks may not accurately reflect clinician efficiency or quality of care and could discourage inclusion of populations served by certain specialties.

Specialist Performance Measurement

First, **CMS should not create specialty-care specific measures within the ACO; rather, CMS should leverage existing claims-based outcome and utilization measures within MSSP and other APMs to assess the effectiveness of specialist engagement.** Performance on TCOC, care coordination, avoidable hospitalizations, and readmissions already reflect how effectively specialists contribute to population health management. CMS should build on approaches already used in Medicare Advantage and other risk-based models by continuing to hold ACOs accountable for population-level quality, cost, and

outcome measures that specialists already contribute to, rather than creating additional specialty-specific measure sets and performance requirements.

Additionally, CMS should reduce the administrative burden associated with quality reporting and performance measurement. Aligning measures and accountability frameworks across MSSP, Medicare Advantage, and other value-based payment models would promote consistency, reduce duplicative reporting requirements, leverage existing data infrastructure, and support broader participation in accountable care arrangements, allowing clinicians to focus resources on improving quality outcomes and performance.

Next, **CMS should exempt clinicians who already participate in ACOs or other TCOC APMs from mandatory MVP reporting requirements.** NAACOS continues to have serious concerns about applying mandatory MVP-based reporting to specialists who already participate in ACOs or other TCOC Advanced APMs. MVP requirements impose significant administrative burden on clinicians and have not resolved fundamental challenges related to duplicative reporting, attribution, small sample sizes, data availability, and measure applicability. Before expanding MVP-based accountability requirements, CMS should prioritize strengthening specialist engagement within accountable care models.

Additional Approaches to Support ACOs with Specialist Engagement
Once existing barriers are addressed and a stronger foundation for participation is established, CMS should consider approaches to support ACOs with downstream payment arrangements for specialists.

Rather than creating additional standalone bundled payment models, CMS should align and integrate episode-based payment approaches within broader TCOC frameworks. Specifically, CMS should offer nested bundles (e.g., expanding CARA to MSSP) and expanded capitation to support downstream payment arrangements. These two approaches within accountable care arrangements can promote alignment across payers, reduce fragmentation, and reinforce shared accountability for patient outcomes and spending.

ACOs should retain flexibility to determine the specialist engagement and payment strategies that best meet the needs of the patients they serve without requiring downstream arrangements. Both nested bundles and expanded capitation approaches can support a variety of ACOs and specialist arrangements. The NAACOS Specialty Care Engagement Toolkit provides insights into various arrangements.

For example, specialists focused on procedures are better suited for nested bundled payments as services are tied to defined episodes of care and hold specialists accountable for care transitions, site of care criteria, and outcomes. Specialists managing chronic conditions through longitudinal patient relationships are better aligned with sub-capitated, population-based, or other VBC arrangements that support shared accountability for care management, outcomes, and TCOC. Specialists treating high-need, high-cost populations may require targeted incentives and enhanced care coordination models to support the management of complex patients, such as embedded or closely coordinated specialty support for high-risk populations.

In health system-led ACOs, specialists are often engaged through employment relationships, governance structures, and aligned quality and population health goals, with additional incentives used to support contracted or network-affiliated specialists. In convener ACOs, specialist engagement is typically supported through clinician enablement, data analytics, operational infrastructure, and financial

arrangements that align accountability with care quality, outcomes, and cost. In small, community-based ACOs, specialist engagement relies more heavily on collaborative relationships with independent providers and is best supported through streamlined communication, timely data sharing, clearly defined care pathways, and practical incentives that facilitate care coordination while minimizing administrative burden.

Accordingly, CMS should support the range of specialist options ranging from quality-based incentives, nested bundles, partial sub-capitation models, and more advanced capitated, risk-bearing arrangements. Preserving flexibility across these approaches would enable ACOs to adopt models that best reflect specialty-specific capabilities, patient populations, provider relationships, and readiness for financial risk while supporting locally driven innovation.

QUALITY PAYMENT PROGRAM

Merit Based Incentive Payment System (MIPS)

Transition to MVPs

NAACOS appreciates the opportunity to comment on CMS' continued transition toward MIPS Value Pathways (MVPs) reporting. As detailed in our comments on prior fee schedule proposed rules, **NAACOS has consistently raised concerns with efforts to mandate MVP reporting for specialists, particularly those participating in ACOs and other total cost of care (TCOC) alternative payment models (APMs).** CMS should instead focus on fundamental reforms to the MIPS program that would adequately prepare clinicians to transition into Advanced APMs.

Implications for ACOs and Specialists in Total Cost of Care Models. First, consistent with our prior comments, **NAACOS continues to have serious concerns about applying mandatory MVP-based reporting – whether through the current MVP framework or the ASM– to specialists who already participate in ACOs or other TCOC APMs**. Layering an additional, and in many cases clinically mismatched, MVP reporting requirement onto specialists already accountable for cost and quality through their ACO participation creates duplicative burden without a clear benefit to patients or the program. The coverage and measure-sufficiency gaps identified below make this concern more acute: specialists in ACOs who lack an appropriate MVP, or whose applicable MVP contains too few relevant measures, would be forced either to report on measures unrelated to their practice or risk non-compliance through no fault of their own. **We reiterate our recommendation that CMS should not apply mandatory MVP reporting requirements to clinicians who participate in ACOs or other TCOC APMs, and instead focus on strengthening data sharing, attribution, and payment tools that support specialist engagement directly within accountable care models.**

MVPs Replacing Traditional MIPS. Before requiring MVP reporting in place of traditional MIPS, CMS must conduct a robust, transparent process to identify remaining measure gaps and develop a corresponding measure development plan – both for specialties that currently lack any applicable MVP and for subspecialties, clinical conditions, and procedures that existing MVPs do not adequately address. This work would allow medical specialty societies and other stakeholders to focus their measure development efforts on the identified gaps and would give CMS the information it needs to establish a realistic and appropriate timeline for any transition to MVP-only reporting.

Below we provide additional analysis on the readiness of the MVP framework to serve as a replacement for traditional MIPS.

Specialty Coverage Remains Incomplete

CMS estimates that if the additional three proposed MVPs are finalized, approximately 98 percent of specialties will be covered. We urge CMS to ensure that 100 percent of all specialties can report using an applicable MVP before requiring MVP reporting, as there remain specialties for which no relevant MVP exists. Allergy and immunology is one such example. We also believe CMS' 98 percent estimate is inaccurate, and that a more thorough analysis of remaining coverage gaps must be completed before CMS moves to sunset traditional MIPS reporting.

Analysis of Existing MVPs Reveals Significant Gaps

We compared the existing MIPS specialty measure sets against the proposed and finalized MVPs to assess the potential effect on clinicians if traditional MIPS reporting is eliminated and clinicians are required to report exclusively through MVPs. This analysis surfaced several significant concerns.

Incomplete Coverage of Conditions and Procedures

Many existing MVPs are narrowly defined, limiting a given specialty's ability to report measures relevant to its actual scope of practice. For example:

- The Improving Care for Lower Extremity Joint Repair MVP addresses only hip and knee replacement surgeries, leaving orthopedic surgeons who specialize in hand, shoulder, or sports medicine without an applicable MVP built around their work. The Surgical Care MVP – the next logical option – includes only three general surgery, four cardiothoracic, and three lumbar spine measures, offering these surgeons limited and largely irrelevant reporting options. It is also unclear what CMS plans to do with the “miscellaneous” specialty measures that do not have an applicable MVP by 2029, highlighting another reason CMS should not transition to mandatory MVP reporting.
- The Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP includes three measures on HIV, two on Hepatitis C, and one on upper respiratory infection, but no measures addressing other common conditions treated by infectious disease specialists, such as sepsis or pneumonia. This again demonstrates the lack of a comprehensive measure set for clinicians in this specialty.

Insufficient Number of Meaningful Measures

Even where an applicable MVP exists, the number of clinically meaningful measures within it are often insufficient. MIPS currently requires reporting on a minimum of four quality measures, yet most MVPs do not include four measures relevant to a given condition or procedure. For example, the Gastroenterology Care MVP would offer only two measures related to colonoscopy, assuming 320 (Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients) and NHCR4 (Repeat Screening or Surveillance Colonoscopy Recommended Within One Year Due to Inadequate Bowel Preparation) are removed from the program, three measures on Hepatitis C, and one on inflammatory bowel disease. This lack of a comprehensive measure set forces clinicians to select measures that do not reflect their actual scope of practice, reinforcing the ongoing problem that quality reporting is completed to satisfy program requirements rather than to drive meaningful quality improvement or provide useful information about the care patients receive.

MVPs Substantially Narrow Reporting Flexibility Compared to Specialty Sets

The current MIPS specialty measure sets provide a considerably wider array of reportable measures than the MVPs designed to replace them. For example:

- **Internal Medicine:** 52 measures are available under the current specialty set, compared to just 12 measures in the Value in Primary Care MVP and 18 in the Advancing Care for Heart Disease MVP — the two MVPs identified as most applicable to this specialty. With only 17 measures overlapping between the specialty set and the two MVPs combined, there is a narrow pool of measures from which internists can select.
- **Family Medicine:** 59 specialty set measures are available compared to 19 measures across the Value in Primary Care and Advancing Care for Heart Disease MVPs.
- **Orthopedic Surgery:** 21 specialty set measures are available compared to just seven measures in the Improving Care for Lower Extremity Joint Repair MVP, which covers only hip and knee replacement.
- **Urology:** 21 specialty set measures are available compared to eight measures in the Optimal Care for Patients with Urologic Conditions MVP.
- **Otolaryngology:** 19 specialty set measures are available compared to seven measures in the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP.

A shift to mandatory MVP reporting would substantially reduce clinicians' flexibility to report on, and focus quality improvement efforts on measures appropriate to their actual patient populations. Combined with the limited number of cost measures currently available within MVPs, this reduction in flexibility will further diminish the usefulness and clinical relevance of the MIPS program.

Core Measures

NAACOS supports removing the outcome and high-priority measure reporting requirement and the associated attestation process for clinicians for whom no core measure is applicable, and we support exempting small practices from this requirement. We also agree that the concept of core measures may prove useful as MVP reporting increases, and we agree with the factors CMS has proposed for selecting core measures, such as measure collection type availability and measure adoption. **However, we do not believe the current set of core measures meets CMS' stated goal of identifying measures "most reflective of the care that is unique to each MVP's specialty or medical condition."** We question whether some proposed core measures satisfy that last factor and believe at least one core measure should be paired with a related cost measure within each MVP. On review, this concept works reasonably well for disease-specific MVPs (e.g., Diabetic Disease, Hypertension) but breaks down for broadly applicable MVPs across a specialty, where core measure selection appears driven more by the limited pool of available measures or a desire to avoid QCDR measures than by clinical relevance. This misalignment serves as another example that the MVPs must evolve to become more relevant to the intended specialty before any widespread reporting is required.

APM Performance Pathways (APP) Plus Measure Set

We support the expansion to include Medicare eCQM specifications for the five ACO-reported measures and the proposed changes to *Diabetes: Glycemic Status Assessment Greater Than 9%* (Quality ID: 001) and *Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible MIPS Clinician Groups* (Quality ID: 479). We appreciate CMS' recognition that adding more measures to the set while ACOs continue to adapt to the new reporting requirements would be disruptive and support the removal of two future measures: *Initiation and Engagement of Substance Use Disorder Treatment* (Quality ID: 305) and *Adult Immunization Status* (Quality ID: 493).

While we support CMS' goal of reducing unnecessary administrative and clinical burden associated with the *Preventive Care and Screening: Screening for Depression and Follow-Up Plan* measure (Quality ID: 134), we do not believe the proposed inclusion of a new denominator exclusion achieves that goal. We ask CMS to reconsider the proposal or clarify how it is intended to operate before finalizing the change.

The current specification defines a broad denominator – any patient aged 12 or older with at least one qualifying encounter – and includes many encounters from multiple specialties. This measure is also reported a minimum of once per patient for the performance period and the specification states that "the most recent numerator option/quality data code will be used if the measure is submitted more than once." In practice, this means that when a patient has multiple qualifying encounters with different clinicians across a performance period, whichever encounter is most recent determines the patient's status for the entire measure, regardless of what occurred at earlier encounters.

We acknowledge that the proposed inclusion of the denominator exception addresses some concerns, specifically when a clinician is aware that the screening was previously completed by another clinician but does not have the actual results. However, the proposed change does not completely address the challenges that ACOs encounter when aggregating data across multiple practices and specialties. We believe that the implementation challenges lead to results that do not match the intent of the measure, which is to reflect the quality of services provided to patients screened for depression. The results may be more reflective of the ongoing need for interoperability and timely information at the point of care to facilitate care coordination and appropriate screening and management for depression.

Currently, the numerator calls for screening for depression and, if positive, a follow-up plan to be documented on the date or up to two days after the date of the qualifying encounter. While the specifications state that it is a patient-based measure with the screening only required once per measurement period, it is very possible that a patient will have more than one qualifying encounter in a reporting period. Any initial screens could be replaced by what does or does not occur in a subsequent qualifying visit with a different clinician whose EHR does not include the previous screen and therefore triggers a best practice alert. As ACOs implement and aggregate data, the most recent quality data code is what must be used and it may be the one from a specialist or urgent care visit where the screening did not occur or was incomplete, regardless of what occurred previously. The proposed exception is only useful in those instances where the clinician knows that the screening happened but does not have visibility into the result. It does not address those instances where a more recent encounter results in a numerator failure (e.g., the best practice alert is not addressed during the urgent care visit) even when at some point in the performance period the appropriate screening and follow-up plan, if positive, is documented.

We are also concerned with the lack of alignment with the eCQM versions of this measure since the addition of this new exception is omitted from the eCQM specification for 2027. For those ACOs that may decide to collect data for more than one reporting option or find that they must switch from reporting an eCQM to a MIPS CQM measure mid-year, this addition will require them to maintain two separate pathways and increase reporting complexity and burden. These inconsistencies must be avoided and further demonstrate why CMS should evaluate whether this proposed change sufficiently addresses these concerns and coordinate any updates to ensure all specifications, regardless of data source, are the same for the same reporting year.

If the goal of the measure is to ensure that patients are screened for depression at least once a year, then we recommend that the measure specifications across all reporting options are revised to clarify

that intent. **Specifically, the presence of a screen and follow-up, if appropriate, at least once in a performance period should be sufficient and if multiple screens are completed, then the most recent should be used.** This change would address the current issues when aggregating the data across practices and eliminate the need for the denominator exception, which removes patients due to the lack of available and discrete data and not due to clinical reasons.

Our questions and concerns regarding this proposed denominator exception highlight the ongoing challenges that ACOs experience when implementing measures that were intended to capture the quality of care provided by individual clinicians or practices. Applying the current specifications to ACOs requires them to develop workarounds and new pathways, shifting their focus away from delivering and improving patient care to a focus on successfully reporting the measure. **NAACOS encourages CMS to consider developing and maintaining measure specifications for ACO use specifically.** Convening ACOs with the measure developers to review the specifications and discuss ways to further improve the measures when applied at the ACO level is needed. Updates to measures must also be coordinated to ensure that specification changes are consistent across all reporting options within a reporting year.

APP Submissions

While CMS does not propose such changes in this rule, we urge CMS to add additional security protections to Authorized Officials of the QPP accounts to ensure only Authorized Officials can submit a quality submission on an ACO's behalf. We also urge CMS to create notifications that are sent to all QPP Authorized Officials when a quality submission is submitted on behalf of an ACO. Because ACOs are sending CMS an aggregate submission that includes multiple practices' data, there is the possibility for confusion among ACO participant TINs, as well as vendors they use, regarding how submissions are completed. This confusion can occur despite ongoing communications from the ACO about the process. Member ACOs have raised challenges with NAACOS when quality submissions were inadvertently submitted on behalf of the ACO rather than the participant TIN, particularly when this occurs close to the reporting deadline. When a misunderstanding like this occurs, there is currently no communication to the ACO to help identify the error, and overriding the submission can be a difficult process, particularly if a practice leader or vendor may be out of the office and unable to help rectify it. We believe the ACO should retain the sole right to submit data and should at a minimum receive communication when a submission has been reported on the ACO's behalf to alert leadership if there has been an error and to give sufficient time to resolve the issue.

Promoting Interoperability Category

We appreciate CMS' ongoing efforts to ensure that the requirements within this category are aligned with the Office of the National Coordinator (ONC) for Health Information Technology certification criteria and reduce reporting burden where possible. We support the removal of the required ONC Direct Review attestation, the optional ONC-ACB Surveillance attestation, and the Security Risk Analysis measure. We also agree with the updates to the Electronic Prior Authorization measure and the addition of the new measure on Electronic Prior Authorization for Prescription Drugs in the CY 2028 performance period. NAACOS would like to reiterate past concerns that certification criteria do not sufficiently require vendor products to support ACO practices in meeting CMS requirements. **We strongly encourage CMS to work closely with ONC to ensure certification criteria enforce minimum standards that enable clinicians and practices to successfully meet CMS reporting requirements.** This will be particularly critical as CMS continues to pursue the transition to digital quality measurement.

Request for Information: Star Rating Assignment Methodology for Administrative Claims

NAACOS supports the ongoing efforts to improve how clinician performance on quality and cost measures are represented. We recommend that CMS consider applying the same methodology changes to all quality and cost measures, regardless of data source since there is, to our knowledge, no cogent reason why the benchmarking practices should differ. In addition, performance should only be scored against benchmarks that are established prior to the performance year. This process increases transparency for clinicians on what performance scores they need to achieve and ensures that many can be successful in achieving that standard.

Advanced Alternative Payment Models

QP Thresholds and APM Incentive Payments

CMS is implementing provisions of the Consolidated Appropriations Act, 2026, affecting QP thresholds and the Advanced APM incentive payment. NAACOS supports these statutory changes.

Application of QP and Partial QP Status at the TIN/NPI Level

CMS proposes significant changes to the manner in which QP and Partial QP determinations are applied. Under current policy, a clinician's QP status is applied at the NPI level and therefore carries across all TINs under which the clinician bills. For example, if a clinician achieves QP status through participation in an Advanced APM under one TIN/NPI relationship, that QP status is applied to all of the clinician's TIN/NPI relationships both for purposes of the MIPS exclusion and the financial benefits associated with QP status. Partial QPs similarly may elect not to participate in MIPS based on their clinician-level determination.

CMS proposes to change this policy and apply QP and Partial QP determination at the TIN/NPI level, such that the QP conversion factor and, where applicable, the APM Incentive Payment would apply only to those services billed through the TIN or TINs in which the clinician achieved QP status. Similarly, clinicians would be exempt from MIPS only for the TIN/NPIs under which they achieved QP status.

NAACOS has significant concerns with the TIN/NPI-level approach proposed by CMS and urges the agency not to finalize the policy as proposed. The policy would create substantial new administrative complexity and weaken incentives for APM participation. Moreover, we raise serious questions regarding CMS' statutory authority to implement the proposal.

First, the proposed approach creates significant operational and burden concerns for the qualifying APM conversion factor. The same clinician's services could be paid under different PFS conversion factors depending solely on the TIN through which a claim is submitted. This would further complicate financial forecasting and practice management for all ACOs. Moreover, this would create uncertainty – and potentially unintended disincentives – for clinicians considering changes in employment, practice affiliation, or ACO participation. As the statutory updates to the qualifying and nonqualifying conversion factors diverge and compound over time, the financial consequences of moving between TINs could grow substantially in future years. ACOs and practices will need to account not only for differences among clinicians, but also for differences in payment for the same clinician depending on the TIN through which services are billed.

Second, limiting the MIPS exemption to individual TIN/NPI combinations would increase administrative complexity. A clinician could be treated as a QP through one practice while remaining subject to MIPS requirements through another. This would require clinicians and organizations to manage different QPP obligations for the same clinician depending on the billing relationship. This complexity may be

particularly acute for ACOs that include clinicians who bill through multiple TINs, as the ACO and its participating practices may need to track a clinician's QP status and corresponding MIPS obligations separately across different billing arrangements. NAACOS has long recommended that APM participation should provide meaningful relief from MIPS because burden reduction is an important non-financial incentive for participation in APMs. Policies that expose APM clinicians to additional MIPS requirements risk weakening this incentive.

Third, the proposal would reduce the value of QP status for clinicians who furnish services through multiple TINs, particularly as the program initially moves away from a larger APM incentive payment and transitions to the differential conversion factor update. Reducing the financial value of QP status could make it more difficult for ACOs to recruit and retain clinicians. Additionally, NAACOS has previously emphasized that ACOs coordinate care across the continuum and that increasing specialist participation in total-cost-of-care models should be a CMS priority. The proposal moves in the opposite direction by making participation in an Advanced APM less valuable for clinicians, specialists in particular, whose practice patterns often span multiple organizations.

Finally, NAACOS questions whether applying QP status at the TIN/NPI level is consistent with statute. MACRA consistently frames QP status as a characteristic of an eligible professional, not of an individual billing relationship. Section 1833(z)(2) of the Social Security Act defines a "qualifying APM participant" as an "eligible professional" who satisfies the applicable participation threshold. Similarly, section 1848(q)(1)(C)(ii) excludes an eligible professional who "is a qualifying APM participant" from the definition of a MIPS eligible professional. These provisions do not establish separate QP determinations for each TIN through which the eligible professional furnishes services.

The statutory provisions governing QP financial incentives reinforce this clinician-level structure. Section 1833(z)(1)(A) provides that, for a qualifying APM participant, the Secretary shall make the applicable incentive payment to "such professional" based on the estimated aggregate payments for covered professional services furnished by "such professional." Likewise, section 1848(d)(1)(A) establishes a qualifying APM conversion factor for "items and services furnished by a qualifying APM participant." The statute does not state that an individual is a QP for some services but not others based on the billing TIN.

CMS estimates that the proposed change would reduce QP-related payments by approximately $2.38 billion over the next decade. The magnitude of this estimate underscores the importance of understanding how the change could affect clinician behavior and APM participation. A reduction in incentive payments should be evaluated not only as a budgetary effect but also for its potential consequences for clinician recruitment, retention, and engagement in accountable care.

APM incentives are intended to encourage and sustain participation in models that hold providers accountable for total cost of care and quality. If reducing those incentives causes fewer clinicians to enter or remain in Advanced APMs, any near-term reduction in physician payments could be offset by foregone savings from lower APM participation over time. A complete impact analysis should therefore consider behavioral effects, including the potential loss of savings generated when clinicians and organizations move away from value-based care. A policy that saves money on APM incentives but weakens adoption of models designed to lower total Medicare spending could ultimately be counterproductive to CMS' broader accountable care goals. Additionally, CMS states in the rule that relatively few QPs would be affected by this proposal, but it provides no estimate of how many clinicians would be impacted or any description of their practice attributes or affiliations. Analyses should

examine the number of clinicians who would have different QP status across their TINs, the proportion of affected clinicians who are specialists, the resulting changes in APM incentive payments and physician payment, the number of clinicians who would be newly exposed to MIPS, and the administrative implications for clinicians practicing through multiple organizations.

For these reasons, **NAACOS urges CMS not to finalize the proposal to apply QP and Partial QP status at the TIN/NPI level.** If CMS believes the current payment methodology provides incentives that are insufficiently connected to actual APM participation, the agency should work with Congress and stakeholders on a statutory redesign of the APM incentive structure rather than redefining QP status administratively. NAACOS appreciates CMS' goal of better aligning APM incentives with actual participation in Advanced APMs. NAACOS has previously recommended to Congress that future incentive payments could be based on revenue flowing through an APM rather than all Part B revenue. This approach could better align payment incentives with meaningful APM participation. NAACOS continues to support consideration of such reforms as part of a broader Congressional modernization of MACRA.

We encourage CMS to work with ACOs, clinicians, and other stakeholders to develop an approach that better aligns financial incentives with meaningful APM participation without creating new barriers to specialist engagement, increasing MIPS burden, or weakening the overall value of QP status. If CMS nevertheless proceeds with changes intended to better target financial incentives, the agency should preserve clinician-level (1) application of the qualifying APM conversion factor to avoid significant administrative complexity and (2) relief from MIPS and ensure that clinicians participating in ACOs are not subjected to duplicative reporting requirements.

CONCLUSION

Thank you for the opportunity to provide feedback on the proposed CY 2027 PFS rule. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health. We look forward to our continued engagement to drive sustainability and innovation in accountable care. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at apittman@naacos.com.

Sincerely,

Emily D. Brower
President and CEO
NAACOS